

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 393.0661, F.S.;
3 requiring the Agency for Persons with Disabilities to
4 establish a transition plan for current Medicaid
5 recipients of home and community-based services under
6 certain circumstances; providing for expiration of the
7 section on a specified date; amending s. 393.0662, F.S.;
8 requiring the Agency for Persons with Disabilities to
9 complete the transition for current Medicaid recipients of
10 home and community-based services to the iBudget system by
11 a specified date; requiring the Agency for Persons with
12 Disabilities to develop a transition plan for current
13 Medicaid recipients of home and community-based services
14 to managed care plans; providing for expiration of the
15 section on a specified date; amending s. 408.040, F.S.;
16 providing for suspension of certain conditions precedent
17 to the issuance of a certificate of need for a nursing
18 home, effective on a specified date; amending s. 408.0435,
19 F.S.; extending the certificate-of-need moratorium for
20 additional community nursing home beds; designating ss.
21 409.016-409.803, F.S., as pt. I of ch. 409, F.S., and
22 entitling the part "Social and Economic Assistance";
23 designating ss. 409.810-409.821, F.S., as pt. II of ch.
24 409, F.S., and entitling the part "Kidcare"; designating
25 ss. 409.901-409.9205, F.S., as part III of ch. 409, F.S.,
26 and entitling the part "Medicaid"; amending s. 409.905,
27 F.S.; requiring the Agency for Health Care Administration
28 to set reimbursements rates for hospitals that provide

29 Medicaid services based on allowable-cost reporting from
30 the hospitals; providing the methodology for the rate
31 calculation and adjustments; requiring the rates to be
32 subject to certain limits or ceilings; providing that
33 exemptions to the limits or ceilings may be provided in
34 the General Appropriations Act; deleting provisions
35 relating to agency adjustments to a hospital's inpatient
36 per diem rate; directing the agency to develop a plan to
37 convert inpatient hospital rates to a prospective payment
38 system that categorizes each case into diagnosis-related
39 groups; requiring a report to the Governor and
40 Legislature; amending s. 409.907, F.S.; providing
41 additional requirements for provider agreements for
42 Medicare crossover providers; providing that the agency is
43 not obligated to enroll certain providers as Medicare
44 crossover providers; specifying additional requirements
45 for certain providers; providing the agency may establish
46 additional criteria for providers to promote program
47 integrity; amending s. 409.911, F.S.; providing for
48 expiration of the Medicaid Low-Income Pool Council;
49 amending s. 409.912, F.S.; providing payment requirements
50 for provider service networks; providing for the
51 expiration of various provisions relating to agency
52 contracts and agreements with certain entities on
53 specified dates to conform to the reorganization of
54 Medicaid managed care; requiring the agency to contract on
55 a prepaid or fixed-sum basis with certain prepaid dental
56 health plans; eliminating obsolete provisions and updating

57 | provisions, to conform; amending ss. 409.91195 and
58 | 409.91196, F.S.; conforming cross-references; repealing s.
59 | 409.91207, F.S., relating to the medical home pilot
60 | project; amending s. 409.91211, F.S.; conforming cross-
61 | references; providing for future repeal of s. 409.91211,
62 | F.S., relating to the Medicaid managed care pilot program;
63 | amending s. 409.9122, F.S.; providing for the expiration
64 | of provisions relating to mandatory enrollment in a
65 | Medicaid managed care plan or MediPass on specified dates
66 | to conform to the reorganization of Medicaid managed care;
67 | eliminating obsolete provisions; requiring the agency to
68 | develop a process to enable any recipient with access to
69 | employer-sponsored coverage to opt out of eligible plans
70 | in the Medicaid program; requiring the agency, contingent
71 | on federal approval, to enable recipients with access to
72 | other coverage or related products that provide access to
73 | specified health care services to opt out of eligible
74 | plans in the Medicaid program; requiring the agency to
75 | maintain and operate the Medicaid Encounter Data System;
76 | requiring the agency to conduct a review of encounter data
77 | and publish the results of the review before adjusting
78 | rates for prepaid plans; authorizing the agency to
79 | establish a designated payment for specified Medicare
80 | Advantage Special Needs members; authorizing the agency to
81 | develop a designated payment for Medicaid-only covered
82 | services for which the state is responsible; requiring the
83 | agency to establish, and managed care plans to use, a
84 | uniform method of accounting for and reporting medical and

85 nonmedical costs; authorizing the agency to create
86 exceptions to mandatory enrollment in managed care under
87 specified circumstances; requiring the agency to contract
88 with a provider service network to function as a third-
89 party administrator and managing entity for the MediPass
90 program; providing contract provisions; providing for the
91 expiration of such contract requirements on a specified
92 date; requiring the agency to contract with a single
93 provider service network to function as a third-party
94 administrator and managing entity for the Medically Needy
95 program; providing contract provisions; providing for the
96 expiration of such contract requirements on a specified
97 date; amending s. 430.04, F.S.; eliminating obsolete
98 provisions; requiring the Department of Elderly Affairs to
99 develop a transition plan for specified elders and
100 disabled adults receiving long-term care Medicaid services
101 when eligible plans become available; providing for
102 expiration of the plan; amending s. 430.2053, F.S.;
103 eliminating obsolete provisions; providing additional
104 duties of aging resource centers; providing an additional
105 exception to direct services that may not be provided by
106 an aging resource center; providing an expiration date for
107 certain services administered through aging resource
108 centers; providing for the cessation of specified payments
109 by the department as eligible plans become available;
110 providing for a memorandum of understanding between the
111 agency and aging resource centers under certain
112 circumstances; eliminating provisions requiring reports;

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113 | repealing s. 430.701, F.S., relating to legislative
114 | findings and intent and approval for action relating to
115 | provider enrollment levels; repealing s. 430.702, F.S.,
116 | relating to the Long-Term Care Community Diversion Pilot
117 | Project Act; repealing s. 430.703, F.S., relating to
118 | definitions; repealing s. 430.7031, F.S., relating to the
119 | nursing home transition program; repealing s. 430.704,
120 | F.S., relating to evaluation of long-term care through the
121 | pilot projects; repealing s. 430.705, F.S., relating to
122 | implementation of long-term care community diversion pilot
123 | projects; repealing s. 430.706, F.S., relating to quality
124 | of care; repealing s. 430.707, F.S., relating to
125 | contracts; repealing s. 430.708, F.S., relating to
126 | certificate of need; repealing s. 430.709, F.S., relating
127 | to reports and evaluations; renumbering ss. 409.9301,
128 | 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531,
129 | F.S., as ss. 402.81, 402.82, 402.83, 402.84, 402.85,
130 | 402.86, and 402.87, F.S., respectively; amending ss.
131 | 443.111 and 641.386, F.S.; conforming cross-references;
132 | directing the agency to develop a plan to implement the
133 | enrollment of the medically needy into managed care;
134 | amending s. 766.118, F.S.; providing a limitation on
135 | noneconomic damages for negligence of practitioners
136 | providing services and care to Medicaid recipients;
137 | providing effective dates and a contingent effective date.

138 |
139 | Be It Enacted by the Legislature of the State of Florida:
140 |

141 Section 1. Section 393.0661, Florida Statutes, is amended
142 to read:

143 393.0661 Home and community-based services delivery
144 system; comprehensive redesign.—The Legislature finds that the
145 home and community-based services delivery system for persons
146 with developmental disabilities and the availability of
147 appropriated funds are two of the critical elements in making
148 services available. Therefore, it is the intent of the
149 Legislature that the Agency for Persons with Disabilities shall
150 develop and implement a comprehensive redesign of the system.

151 (1) The redesign of the home and community-based services
152 system shall include, at a minimum, all actions necessary to
153 achieve an appropriate rate structure, client choice within a
154 specified service package, appropriate assessment strategies, an
155 efficient billing process that contains reconciliation and
156 monitoring components, and a redefined role for support
157 coordinators that avoids potential conflicts of interest and
158 ensures that family/client budgets are linked to levels of need.

159 (a) The agency shall use an assessment instrument that the
160 agency deems to be reliable and valid, including, but not
161 limited to, the Department of Children and Family Services'
162 Individual Cost Guidelines or the agency's Questionnaire for
163 Situational Information. The agency may contract with an
164 external vendor or may use support coordinators to complete
165 client assessments if it develops sufficient safeguards and
166 training to ensure ongoing inter-rater reliability.

167 (b) The agency, with the concurrence of the Agency for
168 Health Care Administration, may contract for the determination

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169 of medical necessity and establishment of individual budgets.

170 (2) A provider of services rendered to persons with
171 developmental disabilities pursuant to a federally approved
172 waiver shall be reimbursed according to a rate methodology based
173 upon an analysis of the expenditure history and prospective
174 costs of providers participating in the waiver program, or under
175 any other methodology developed by the Agency for Health Care
176 Administration, in consultation with the Agency for Persons with
177 Disabilities, and approved by the Federal Government in
178 accordance with the waiver.

179 (3) The Agency for Health Care Administration, in
180 consultation with the agency, shall seek federal approval and
181 implement a four-tiered waiver system to serve eligible clients
182 through the developmental disabilities and family and supported
183 living waivers. The agency shall assign all clients receiving
184 services through the developmental disabilities waiver to a tier
185 based on the Department of Children and Family Services'
186 Individual Cost Guidelines, the agency's Questionnaire for
187 Situational Information, or another such assessment instrument
188 deemed to be valid and reliable by the agency; client
189 characteristics, including, but not limited to, age; and other
190 appropriate assessment methods.

191 (a) Tier one is limited to clients who have service needs
192 that cannot be met in tier two, three, or four for intensive
193 medical or adaptive needs and that are essential for avoiding
194 institutionalization, or who possess behavioral problems that
195 are exceptional in intensity, duration, or frequency and present
196 a substantial risk of harm to themselves or others. Total annual

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197 expenditures under tier one may not exceed \$150,000 per client
198 each year, provided that expenditures for clients in tier one
199 with a documented medical necessity requiring intensive
200 behavioral residential habilitation services, intensive
201 behavioral residential habilitation services with medical needs,
202 or special medical home care, as provided in the Developmental
203 Disabilities Waiver Services Coverage and Limitations Handbook,
204 are not subject to the \$150,000 limit on annual expenditures.

205 (b) Tier two is limited to clients whose service needs
206 include a licensed residential facility and who are authorized
207 to receive a moderate level of support for standard residential
208 habilitation services or a minimal level of support for behavior
209 focus residential habilitation services, or clients in supported
210 living who receive more than 6 hours a day of in-home support
211 services. Total annual expenditures under tier two may not
212 exceed \$53,625 per client each year.

213 (c) Tier three includes, but is not limited to, clients
214 requiring residential placements, clients in independent or
215 supported living situations, and clients who live in their
216 family home. Total annual expenditures under tier three may not
217 exceed \$34,125 per client each year.

218 (d) Tier four includes individuals who were enrolled in
219 the family and supported living waiver on July 1, 2007, who
220 shall be assigned to this tier without the assessments required
221 by this section. Tier four also includes, but is not limited to,
222 clients in independent or supported living situations and
223 clients who live in their family home. Total annual expenditures
224 under tier four may not exceed \$14,422 per client each year.

225 (e) The Agency for Health Care Administration shall also
226 seek federal approval to provide a consumer-directed option for
227 persons with developmental disabilities which corresponds to the
228 funding levels in each of the waiver tiers. The agency shall
229 implement the four-tiered waiver system beginning with tiers
230 one, three, and four and followed by tier two. The agency and
231 the Agency for Health Care Administration may adopt rules
232 necessary to administer this subsection.

233 (f) The agency shall seek federal waivers and amend
234 contracts as necessary to make changes to services defined in
235 federal waiver programs administered by the agency as follows:

236 1. Supported living coaching services may not exceed 20
237 hours per month for persons who also receive in-home support
238 services.

239 2. Limited support coordination services is the only type
240 of support coordination service that may be provided to persons
241 under the age of 18 who live in the family home.

242 3. Personal care assistance services are limited to 180
243 hours per calendar month and may not include rate modifiers.
244 Additional hours may be authorized for persons who have
245 intensive physical, medical, or adaptive needs if such hours are
246 essential for avoiding institutionalization.

247 4. Residential habilitation services are limited to 8
248 hours per day. Additional hours may be authorized for persons
249 who have intensive medical or adaptive needs and if such hours
250 are essential for avoiding institutionalization, or for persons
251 who possess behavioral problems that are exceptional in
252 intensity, duration, or frequency and present a substantial risk

253 of harming themselves or others. This restriction shall be in
 254 effect until the four-tiered waiver system is fully implemented.

255 5. Chore services, nonresidential support services, and
 256 homemaker services are eliminated. The agency shall expand the
 257 definition of in-home support services to allow the service
 258 provider to include activities previously provided in these
 259 eliminated services.

260 6. Massage therapy, medication review, and psychological
 261 assessment services are eliminated.

262 7. The agency shall conduct supplemental cost plan reviews
 263 to verify the medical necessity of authorized services for plans
 264 that have increased by more than 8 percent during either of the
 265 2 preceding fiscal years.

266 8. The agency shall implement a consolidated residential
 267 habilitation rate structure to increase savings to the state
 268 through a more cost-effective payment method and establish
 269 uniform rates for intensive behavioral residential habilitation
 270 services.

271 9. Pending federal approval, the agency may extend current
 272 support plans for clients receiving services under Medicaid
 273 waivers for 1 year beginning July 1, 2007, or from the date
 274 approved, whichever is later. Clients who have a substantial
 275 change in circumstances which threatens their health and safety
 276 may be reassessed during this year in order to determine the
 277 necessity for a change in their support plan.

278 10. The agency shall develop a plan to eliminate
 279 redundancies and duplications between in-home support services,
 280 companion services, personal care services, and supported living

281 coaching by limiting or consolidating such services.

282 11. The agency shall develop a plan to reduce the
 283 intensity and frequency of supported employment services to
 284 clients in stable employment situations who have a documented
 285 history of at least 3 years' employment with the same company or
 286 in the same industry.

287 (4) The geographic differential for Miami-Dade, Broward,
 288 and Palm Beach Counties for residential habilitation services
 289 shall be 7.5 percent.

290 (5) The geographic differential for Monroe County for
 291 residential habilitation services shall be 20 percent.

292 (6) Effective January 1, 2010, and except as otherwise
 293 provided in this section, a client served by the home and
 294 community-based services waiver or the family and supported
 295 living waiver funded through the agency shall have his or her
 296 cost plan adjusted to reflect the amount of expenditures for the
 297 previous state fiscal year plus 5 percent if such amount is less
 298 than the client's existing cost plan. The agency shall use
 299 actual paid claims for services provided during the previous
 300 fiscal year that are submitted by October 31 to calculate the
 301 revised cost plan amount. If the client was not served for the
 302 entire previous state fiscal year or there was any single change
 303 in the cost plan amount of more than 5 percent during the
 304 previous state fiscal year, the agency shall set the cost plan
 305 amount at an estimated annualized expenditure amount plus 5
 306 percent. The agency shall estimate the annualized expenditure
 307 amount by calculating the average of monthly expenditures,
 308 beginning in the fourth month after the client enrolled,

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309 interrupted services are resumed, or the cost plan was changed
310 by more than 5 percent and ending on August 31, 2009, and
311 multiplying the average by 12. In order to determine whether a
312 client was not served for the entire year, the agency shall
313 include any interruption of a waiver-funded service or services
314 lasting at least 18 days. If at least 3 months of actual
315 expenditure data are not available to estimate annualized
316 expenditures, the agency may not rebase a cost plan pursuant to
317 this subsection. The agency may not rebase the cost plan of any
318 client who experiences a significant change in recipient
319 condition or circumstance which results in a change of more than
320 5 percent to his or her cost plan between July 1 and the date
321 that a rebased cost plan would take effect pursuant to this
322 subsection.

323 (7) Nothing in this section or in any administrative rule
324 shall be construed to prevent or limit the Agency for Health
325 Care Administration, in consultation with the Agency for Persons
326 with Disabilities, from adjusting fees, reimbursement rates,
327 lengths of stay, number of visits, or number of services, or
328 from limiting enrollment, or making any other adjustment
329 necessary to comply with the availability of moneys and any
330 limitations or directions provided for in the General
331 Appropriations Act.

332 (8) The Agency for Persons with Disabilities shall submit
333 quarterly status reports to the Executive Office of the
334 Governor, the chair of the Senate Ways and Means Committee or
335 its successor, and the chair of the House Fiscal Council or its
336 successor regarding the financial status of home and community-

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337 based services, including the number of enrolled individuals who
338 are receiving services through one or more programs; the number
339 of individuals who have requested services who are not enrolled
340 but who are receiving services through one or more programs,
341 with a description indicating the programs from which the
342 individual is receiving services; the number of individuals who
343 have refused an offer of services but who choose to remain on
344 the list of individuals waiting for services; the number of
345 individuals who have requested services but who are receiving no
346 services; a frequency distribution indicating the length of time
347 individuals have been waiting for services; and information
348 concerning the actual and projected costs compared to the amount
349 of the appropriation available to the program and any projected
350 surpluses or deficits. If at any time an analysis by the agency,
351 in consultation with the Agency for Health Care Administration,
352 indicates that the cost of services is expected to exceed the
353 amount appropriated, the agency shall submit a plan in
354 accordance with subsection (7) to the Executive Office of the
355 Governor, the chair of the Senate Ways and Means Committee or
356 its successor, and the chair of the House Fiscal Council or its
357 successor to remain within the amount appropriated. The agency
358 shall work with the Agency for Health Care Administration to
359 implement the plan so as to remain within the appropriation.

360 (9) The agency shall develop a transition plan for
361 recipients who are receiving services in one of the four waiver
362 tiers at the time eligible managed care plans are available in
363 each recipient's region as defined in s. 409.989 to enroll those
364 recipients in eligible plans.

365 (10) This section expires October 1, 2016.

366 Section 2. Section 393.0662, Florida Statutes, is amended
367 to read:

368 393.0662 Individual budgets for delivery of home and
369 community-based services; iBudget system established.—The
370 Legislature finds that improved financial management of the
371 existing home and community-based Medicaid waiver program is
372 necessary to avoid deficits that impede the provision of
373 services to individuals who are on the waiting list for
374 enrollment in the program. The Legislature further finds that
375 clients and their families should have greater flexibility to
376 choose the services that best allow them to live in their
377 community within the limits of an established budget. Therefore,
378 the Legislature intends that the agency, in consultation with
379 the Agency for Health Care Administration, develop and implement
380 a comprehensive redesign of the service delivery system using
381 individual budgets as the basis for allocating the funds
382 appropriated for the home and community-based services Medicaid
383 waiver program among eligible enrolled clients. The service
384 delivery system that uses individual budgets shall be called the
385 iBudget system.

386 (1) The agency shall establish an individual budget,
387 referred to as an iBudget, for each individual served by the
388 home and community-based services Medicaid waiver program. The
389 funds appropriated to the agency shall be allocated through the
390 iBudget system to eligible, Medicaid-enrolled clients. The
391 iBudget system shall be designed to provide for: enhanced client
392 choice within a specified service package; appropriate

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393 assessment strategies; an efficient consumer budgeting and
394 billing process that includes reconciliation and monitoring
395 components; a redefined role for support coordinators that
396 avoids potential conflicts of interest; a flexible and
397 streamlined service review process; and a methodology and
398 process that ensures the equitable allocation of available funds
399 to each client based on the client's level of need, as
400 determined by the variables in the allocation algorithm.

401 (a) In developing each client's iBudget, the agency shall
402 use an allocation algorithm and methodology. The algorithm shall
403 use variables that have been determined by the agency to have a
404 statistically validated relationship to the client's level of
405 need for services provided through the home and community-based
406 services Medicaid waiver program. The algorithm and methodology
407 may consider individual characteristics, including, but not
408 limited to, a client's age and living situation, information
409 from a formal assessment instrument that the agency determines
410 is valid and reliable, and information from other assessment
411 processes.

412 (b) The allocation methodology shall provide the algorithm
413 that determines the amount of funds allocated to a client's
414 iBudget. The agency may approve an increase in the amount of
415 funds allocated, as determined by the algorithm, based on the
416 client having one or more of the following needs that cannot be
417 accommodated within the funding as determined by the algorithm
418 and having no other resources, supports, or services available
419 to meet the need:

420 1. An extraordinary need that would place the health and

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421 safety of the client, the client's caregiver, or the public in
422 immediate, serious jeopardy unless the increase is approved. An
423 extraordinary need may include, but is not limited to:

424 a. A documented history of significant, potentially life-
425 threatening behaviors, such as recent attempts at suicide,
426 arson, nonconsensual sexual behavior, or self-injurious behavior
427 requiring medical attention;

428 b. A complex medical condition that requires active
429 intervention by a licensed nurse on an ongoing basis that cannot
430 be taught or delegated to a nonlicensed person;

431 c. A chronic comorbid condition. As used in this
432 subparagraph, the term "comorbid condition" means a medical
433 condition existing simultaneously but independently with another
434 medical condition in a patient; or

435 d. A need for total physical assistance with activities
436 such as eating, bathing, toileting, grooming, and personal
437 hygiene.

438

439 However, the presence of an extraordinary need alone does not
440 warrant an increase in the amount of funds allocated to a
441 client's iBudget as determined by the algorithm.

442 2. A significant need for one-time or temporary support or
443 services that, if not provided, would place the health and
444 safety of the client, the client's caregiver, or the public in
445 serious jeopardy, unless the increase is approved. A significant
446 need may include, but is not limited to, the provision of
447 environmental modifications, durable medical equipment, services
448 to address the temporary loss of support from a caregiver, or

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449 special services or treatment for a serious temporary condition
450 when the service or treatment is expected to ameliorate the
451 underlying condition. As used in this subparagraph, the term
452 "temporary" means a period of fewer than 12 continuous months.
453 However, the presence of such significant need for one-time or
454 temporary supports or services alone does not warrant an
455 increase in the amount of funds allocated to a client's iBudget
456 as determined by the algorithm.

457 3. A significant increase in the need for services after
458 the beginning of the service plan year that would place the
459 health and safety of the client, the client's caregiver, or the
460 public in serious jeopardy because of substantial changes in the
461 client's circumstances, including, but not limited to, permanent
462 or long-term loss or incapacity of a caregiver, loss of services
463 authorized under the state Medicaid plan due to a change in age,
464 or a significant change in medical or functional status which
465 requires the provision of additional services on a permanent or
466 long-term basis that cannot be accommodated within the client's
467 current iBudget. As used in this subparagraph, the term "long-
468 term" means a period of 12 or more continuous months. However,
469 such significant increase in need for services of a permanent or
470 long-term nature alone does not warrant an increase in the
471 amount of funds allocated to a client's iBudget as determined by
472 the algorithm.

473
474 The agency shall reserve portions of the appropriation for the
475 home and community-based services Medicaid waiver program for
476 adjustments required pursuant to this paragraph and may use the

477 services of an independent actuary in determining the amount of
478 the portions to be reserved.

479 (c) A client's iBudget shall be the total of the amount
480 determined by the algorithm and any additional funding provided
481 pursuant to paragraph (b). A client's annual expenditures for
482 home and community-based services Medicaid waiver services may
483 not exceed the limits of his or her iBudget. The total of all
484 clients' projected annual iBudget expenditures may not exceed
485 the agency's appropriation for waiver services.

486 (2) The Agency for Health Care Administration, in
487 consultation with the agency, shall seek federal approval to
488 amend current waivers, request a new waiver, and amend contracts
489 as necessary to implement the iBudget system to serve eligible,
490 enrolled clients through the home and community-based services
491 Medicaid waiver program and the Consumer-Directed Care Plus
492 Program.

493 (3) The agency shall transition all eligible, enrolled
494 clients to the iBudget system. The agency may gradually phase in
495 the iBudget system and must complete the phase in by January 1,
496 2015.

497 (a) While the agency phases in the iBudget system, the
498 agency may continue to serve eligible, enrolled clients under
499 the four-tiered waiver system established under s. 393.065 while
500 those clients await transitioning to the iBudget system.

501 (b) The agency shall design the phase-in process to ensure
502 that a client does not experience more than one-half of any
503 expected overall increase or decrease to his or her existing
504 annualized cost plan during the first year that the client is

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505 provided an iBudget due solely to the transition to the iBudget
506 system.

507 (4) A client must use all available services authorized
508 under the state Medicaid plan, school-based services, private
509 insurance and other benefits, and any other resources that may
510 be available to the client before using funds from his or her
511 iBudget to pay for support and services.

512 (5) The service limitations in s. 393.0661(3)(f)1., 2.,
513 and 3. do not apply to the iBudget system.

514 (6) Rates for any or all services established under rules
515 of the Agency for Health Care Administration shall be designated
516 as the maximum rather than a fixed amount for individuals who
517 receive an iBudget, except for services specifically identified
518 in those rules that the agency determines are not appropriate
519 for negotiation, which may include, but are not limited to,
520 residential habilitation services.

521 (7) The agency shall ensure that clients and caregivers
522 have access to training and education to inform them about the
523 iBudget system and enhance their ability for self-direction.
524 Such training shall be offered in a variety of formats and at a
525 minimum shall address the policies and processes of the iBudget
526 system; the roles and responsibilities of consumers, caregivers,
527 waiver support coordinators, providers, and the agency;
528 information available to help the client make decisions
529 regarding the iBudget system; and examples of support and
530 resources available in the community.

531 (8) The agency shall collect data to evaluate the
532 implementation and outcomes of the iBudget system.

533 (9) The agency and the Agency for Health Care
 534 Administration may adopt rules specifying the allocation
 535 algorithm and methodology; criteria and processes for clients to
 536 access reserved funds for extraordinary needs, temporarily or
 537 permanently changed needs, and one-time needs; and processes and
 538 requirements for selection and review of services, development
 539 of support and cost plans, and management of the iBudget system
 540 as needed to administer this section.

541 (10) The agency shall develop a transition plan for
 542 recipients who are receiving services through the iBudget system
 543 at the time eligible managed care plans are available in each
 544 recipient's region defined in s. 409.989 to enroll those
 545 recipients in eligible plans.

546 (11) This section expires October 1, 2016.

547 Section 3. Paragraph (e) of subsection (1) of section
 548 408.040, Florida Statutes, is redesignated as paragraph (d), and
 549 paragraph (b) and present paragraph (d) of that subsection are
 550 amended to read:

551 408.040 Conditions and monitoring.—

552 (1)

553 (b) The agency may consider, in addition to the other
 554 criteria specified in s. 408.035, a statement of intent by the
 555 applicant that a specified percentage of the annual patient days
 556 at the facility will be utilized by patients eligible for care
 557 under Title XIX of the Social Security Act. Any certificate of
 558 need issued to a nursing home in reliance upon an applicant's
 559 statements that a specified percentage of annual patient days
 560 will be utilized by residents eligible for care under Title XIX

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561 of the Social Security Act must include a statement that such
562 certification is a condition of issuance of the certificate of
563 need. The certificate-of-need program shall notify the Medicaid
564 program office and the Department of Elderly Affairs when it
565 imposes conditions as authorized in this paragraph in an area in
566 which a community diversion pilot project is implemented.
567 Effective July 1, 2012, the agency may not consider, or impose
568 conditions or sanctions related to, patient day utilization by
569 patients eligible for care under Title XIX the Social Security
570 Act in making certificate-of-need determinations for nursing
571 homes.

572 ~~(d) If a nursing home is located in a county in which a~~
573 ~~long-term care community diversion pilot project has been~~
574 ~~implemented under s. 430.705 or in a county in which an~~
575 ~~integrated, fixed-payment delivery program for Medicaid~~
576 ~~recipients who are 60 years of age or older or dually eligible~~
577 ~~for Medicare and Medicaid has been implemented under s.~~
578 ~~409.912(5), the nursing home may request a reduction in the~~
579 ~~percentage of annual patient days used by residents who are~~
580 ~~eligible for care under Title XIX of the Social Security Act,~~
581 ~~which is a condition of the nursing home's certificate of need.~~
582 ~~The agency shall automatically grant the nursing home's request~~
583 ~~if the reduction is not more than 15 percent of the nursing~~
584 ~~home's annual Medicaid-patient-days condition. A nursing home~~
585 ~~may submit only one request every 2 years for an automatic~~
586 ~~reduction. A requesting nursing home must notify the agency in~~
587 ~~writing at least 60 days in advance of its intent to reduce its~~
588 ~~annual Medicaid-patient-days condition by not more than 15~~

589 ~~percent. The agency must acknowledge the request in writing and~~
 590 ~~must change its records to reflect the revised certificate of~~
 591 ~~need condition. This paragraph expires June 30, 2011.~~

592 Section 4. Subsection (1) of section 408.0435, Florida
 593 Statutes, is amended to read:

594 408.0435 Moratorium on nursing home certificates of need.—

595 (1) Notwithstanding the establishment of need as provided
 596 for in this chapter, a certificate of need for additional
 597 community nursing home beds may not be approved by the agency
 598 until Medicaid managed care is implemented statewide pursuant to
 599 ss. 409.961-409.992 or October 1, 2016, whichever is earlier
 600 July 1, 2011.

601 Section 5. Sections 409.016 through 409.803, Florida
 602 Statutes, are designated as part I of chapter 409, Florida
 603 Statutes, and entitled "SOCIAL AND ECONOMIC ASSISTANCE."

604 Section 6. Sections 409.810 through 409.821, Florida
 605 Statutes, are designated as part II of chapter 409, Florida
 606 Statutes, and entitled "KIDCARE."

607 Section 7. Sections 409.901 through 409.9205, Florida
 608 Statutes, are designated as part III of chapter 409, Florida
 609 Statutes, and entitled "MEDICAID."

610 Section 8. Paragraph (c) of subsection (5) of section
 611 409.905, Florida Statutes, is amended, and paragraph (g) is
 612 added that subsection, to read:

613 409.905 Mandatory Medicaid services.—The agency may make
 614 payments for the following services, which are required of the
 615 state by Title XIX of the Social Security Act, furnished by
 616 Medicaid providers to recipients who are determined to be

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617 eligible on the dates on which the services were provided. Any
618 service under this section shall be provided only when medically
619 necessary and in accordance with state and federal law.
620 Mandatory services rendered by providers in mobile units to
621 Medicaid recipients may be restricted by the agency. Nothing in
622 this section shall be construed to prevent or limit the agency
623 from adjusting fees, reimbursement rates, lengths of stay,
624 number of visits, number of services, or any other adjustments
625 necessary to comply with the availability of moneys and any
626 limitations or directions provided for in the General
627 Appropriations Act or chapter 216.

628 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
629 all covered services provided for the medical care and treatment
630 of a recipient who is admitted as an inpatient by a licensed
631 physician or dentist to a hospital licensed under part I of
632 chapter 395. However, the agency shall limit the payment for
633 inpatient hospital services for a Medicaid recipient 21 years of
634 age or older to 45 days or the number of days necessary to
635 comply with the General Appropriations Act.

636 (c) The agency shall implement a methodology for
637 establishing base reimbursement rates for each hospital based on
638 allowable costs, as defined by the agency. Rates shall be
639 calculated annually and take effect July 1 of each year based on
640 the most recent complete and accurate cost report submitted by
641 each hospital. Adjustments may not be made to the rates after
642 September 30 of the state fiscal year in which the rate takes
643 effect. Errors in cost reporting or calculation of rates
644 discovered after September 30 must be reconciled in a subsequent

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645 rate period. Cost reports must be reconciled within 5 years
646 after the end of the applicable fiscal year. Hospital rates
647 shall be subject to such limits or ceilings as may be
648 established in law or described in the agency's hospital
649 reimbursement plan. Specific exemptions to the limits or
650 ceilings may be provided in the General Appropriations Act. The
651 ~~agency shall adjust a hospital's current inpatient per diem rate~~
652 ~~to reflect the cost of serving the Medicaid population at that~~
653 ~~institution if:~~

654 1. ~~The hospital experiences an increase in Medicaid~~
655 ~~easeload by more than 25 percent in any year, primarily~~
656 ~~resulting from the closure of a hospital in the same service~~
657 ~~area occurring after July 1, 1995;~~

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

660 3. ~~The hospital is located in a county that has six or~~
661 ~~fewer general acute care hospitals, began offering obstetrical~~
662 ~~services on or after September 1999, and has submitted a request~~
663 ~~in writing to the agency for a rate adjustment after July 1,~~
664 ~~2000, but before September 30, 2000, in which case such~~
665 ~~hospital's Medicaid inpatient per diem rate shall be adjusted to~~
666 ~~cost, effective July 1, 2002.~~

667
668 ~~By October 1 of each year, the agency must provide estimated~~
669 ~~costs for any adjustment in a hospital inpatient per diem rate~~
670 ~~to the Executive Office of the Governor, the House of~~
671 ~~Representatives General Appropriations Committee, and the Senate~~
672 ~~Appropriations Committee. Before the agency implements a change~~

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673 ~~in a hospital's inpatient per diem rate pursuant to this~~
674 ~~paragraph, the Legislature must have specifically appropriated~~
675 ~~sufficient funds in the General Appropriations Act to support~~
676 ~~the increase in cost as estimated by the agency.~~

677 (g) The agency shall develop a plan to convert inpatient
678 hospital rates to a prospective payment system that categorizes
679 each case into diagnosis-related groups (DRG) and assigns a
680 payment weight based on the average resources used to treat
681 Medicaid patients in that DRG. To the extent possible, the
682 agency shall propose an adaptation of an existing prospective
683 payment system, such as the one used by Medicare, and shall
684 propose such adjustments as are necessary for the Medicaid
685 population and to maintain budget neutrality for inpatient
686 hospital expenditures. The agency shall submit the Medicaid DRG
687 plan, identifying all steps necessary for the transition and any
688 costs associated with plan implementation, to the Governor, the
689 President of the Senate, and the Speaker of the House of
690 Representatives no later than January 1, 2013.

691 Section 9. Paragraphs (d) and (e) of subsection (5) of
692 section 409.907, Florida Statutes, are amended to read:

693 409.907 Medicaid provider agreements.—The agency may make
694 payments for medical assistance and related services rendered to
695 Medicaid recipients only to an individual or entity who has a
696 provider agreement in effect with the agency, who is performing
697 services or supplying goods in accordance with federal, state,
698 and local law, and who agrees that no person shall, on the
699 grounds of handicap, race, color, or national origin, or for any
700 other reason, be subjected to discrimination under any program

701 or activity for which the provider receives payment from the
 702 agency.

703 (5) The agency:

704 (d) May enroll entities as Medicare crossover-only
 705 providers for payment and claims processing purposes only. The
 706 provider agreement shall:

707 1. Require that the provider be able to demonstrate to the
 708 satisfaction of the agency that the provider is an eligible
 709 Medicare provider and has a current provider agreement in place
 710 with the Centers for Medicare and Medicaid Services.

711 2. Require the provider to notify the agency immediately
 712 in writing upon being suspended or disenrolled as a Medicare
 713 provider. If the provider does not provide such notification
 714 within 5 business days after suspension or disenrollment,
 715 sanctions may be imposed pursuant to this chapter and the
 716 provider may be required to return funds paid to the provider
 717 during the period of time that the provider was suspended or
 718 disenrolled as a Medicare provider.

719 3. Require the applicant to submit an attestation, as
 720 approved by the agency, that the provider meets the requirements
 721 of Florida Medicaid provider enrollment criteria.

722 4. Require the applicant to submit fingerprints as
 723 required by the agency.

724 ~~5.3.~~ Require that all records pertaining to health care
 725 services provided to each of the provider's recipients be kept
 726 for a minimum of 6 years. The agreement shall also require that
 727 records and any information relating to payments claimed by the
 728 provider for services under the agreement be delivered to the

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729 agency or the Office of the Attorney General Medicaid Fraud
730 Control Unit when requested. If a provider does not provide such
731 records and information when requested, sanctions may be imposed
732 pursuant to this chapter.

733 ~~6.4.~~ Disclose that the agreement is for the purposes of
734 paying and processing Medicare crossover claims only.

735
736 This paragraph pertains solely to Medicare crossover-only
737 providers. In order to become a standard Medicaid provider, the
738 requirements of this section and applicable rules must be met.
739 This paragraph does not create an entitlement or obligation of
740 the agency to enroll all Medicare providers that may be
741 considered a Medicare crossover-only provider in the Medicaid
742 program.

743 (e) Providers that are required to post a surety bond as
744 part of the Medicaid enrollment process are excluded for
745 enrollment under paragraph (d) and must complete a full Medicaid
746 application. The agency may establish additional criteria to
747 promote program integrity.

748 Section 10. Subsection (10) of section 409.911, Florida
749 Statutes, is amended to read:

750 409.911 Disproportionate share program.—Subject to
751 specific allocations established within the General
752 Appropriations Act and any limitations established pursuant to
753 chapter 216, the agency shall distribute, pursuant to this
754 section, moneys to hospitals providing a disproportionate share
755 of Medicaid or charity care services by making quarterly
756 Medicaid payments as required. Notwithstanding the provisions of

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757 s. 409.915, counties are exempt from contributing toward the
758 cost of this special reimbursement for hospitals serving a
759 disproportionate share of low-income patients.

760 (10) The Agency for Health Care Administration shall
761 create a Medicaid Low-Income Pool Council by July 1, 2006. The
762 Low-Income Pool Council shall consist of 24 members, including 2
763 members appointed by the President of the Senate, 2 members
764 appointed by the Speaker of the House of Representatives, 3
765 representatives of statutory teaching hospitals, 3
766 representatives of public hospitals, 3 representatives of
767 nonprofit hospitals, 3 representatives of for-profit hospitals,
768 2 representatives of rural hospitals, 2 representatives of units
769 of local government which contribute funding, 1 representative
770 of family practice teaching hospitals, 1 representative of
771 federally qualified health centers, 1 representative from the
772 Department of Health, and 1 nonvoting representative of the
773 Agency for Health Care Administration who shall serve as chair
774 of the council. Except for a full-time employee of a public
775 entity, an individual who qualifies as a lobbyist under s.
776 11.045 or s. 112.3215 may not serve as a member of the council.
777 Of the members appointed by the Senate President, only one shall
778 be a physician. Of the members appointed by the Speaker of the
779 House of Representatives, only one shall be a physician. The
780 physician member appointed by the Senate President and the
781 physician member appointed by the Speaker of the House of
782 Representatives must be physicians who routinely take calls in a
783 trauma center, as defined in s. 395.4001, or a hospital
784 emergency department. The council shall:

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785 (a) Make recommendations on the financing of the low-
 786 income pool and the disproportionate share hospital program and
 787 the distribution of their funds.

788 (b) Advise the Agency for Health Care Administration on
 789 the development of the low-income pool plan required by the
 790 federal Centers for Medicare and Medicaid Services pursuant to
 791 the Medicaid reform waiver.

792 (c) Advise the Agency for Health Care Administration on
 793 the distribution of hospital funds used to adjust inpatient
 794 hospital rates, rebase rates, or otherwise exempt hospitals from
 795 reimbursement limits as financed by intergovernmental transfers.

796 (d) Submit its findings and recommendations to the
 797 Governor and the Legislature no later than February 1 of each
 798 year.

799

800 This subsection expires October 1, 2014.

801 Section 11. Subsection (4) of section 409.91195, Florida
 802 Statutes, is amended to read:

803 409.91195 Medicaid Pharmaceutical and Therapeutics
 804 Committee.—There is created a Medicaid Pharmaceutical and
 805 Therapeutics Committee within the agency for the purpose of
 806 developing a Medicaid preferred drug list.

807 (4) Upon recommendation of the committee, the agency shall
 808 adopt a preferred drug list as described in s. 409.912 (37) ~~(39)~~.
 809 To the extent feasible, the committee shall review all drug
 810 classes included on the preferred drug list every 12 months, and
 811 may recommend additions to and deletions from the preferred drug
 812 list, such that the preferred drug list provides for medically

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813 appropriate drug therapies for Medicaid patients which achieve
 814 cost savings contained in the General Appropriations Act.

815 Section 12. Subsection (1) of section 409.91196, Florida
 816 Statutes, is amended to read:

817 409.91196 Supplemental rebate agreements; public records
 818 and public meetings exemption.—

819 (1) The rebate amount, percent of rebate, manufacturer's
 820 pricing, and supplemental rebate, and other trade secrets as
 821 defined in s. 688.002 that the agency has identified for use in
 822 negotiations, held by the Agency for Health Care Administration
 823 under s. 409.912 (37) ~~(39)~~ (a)7. are confidential and exempt from
 824 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

825 Section 13. Section 409.912, Florida Statutes, is amended
 826 to read:

827 409.912 Cost-effective purchasing of health care.—The
 828 agency shall purchase goods and services for Medicaid recipients
 829 in the most cost-effective manner consistent with the delivery
 830 of quality medical care. To ensure that medical services are
 831 effectively utilized, the agency may, in any case, require a
 832 confirmation or second physician's opinion of the correct
 833 diagnosis for purposes of authorizing future services under the
 834 Medicaid program. This section does not restrict access to
 835 emergency services or poststabilization care services as defined
 836 in 42 C.F.R. part 438.114. Such confirmation or second opinion
 837 shall be rendered in a manner approved by the agency. The agency
 838 shall maximize the use of prepaid per capita and prepaid
 839 aggregate fixed-sum basis services when appropriate and other
 840 alternative service delivery and reimbursement methodologies,

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841 including competitive bidding pursuant to s. 287.057, designed
842 to facilitate the cost-effective purchase of a case-managed
843 continuum of care. The agency shall also require providers to
844 minimize the exposure of recipients to the need for acute
845 inpatient, custodial, and other institutional care and the
846 inappropriate or unnecessary use of high-cost services. The
847 agency shall contract with a vendor to monitor and evaluate the
848 clinical practice patterns of providers in order to identify
849 trends that are outside the normal practice patterns of a
850 provider's professional peers or the national guidelines of a
851 provider's professional association. The vendor must be able to
852 provide information and counseling to a provider whose practice
853 patterns are outside the norms, in consultation with the agency,
854 to improve patient care and reduce inappropriate utilization.
855 The agency may mandate prior authorization, drug therapy
856 management, or disease management participation for certain
857 populations of Medicaid beneficiaries, certain drug classes, or
858 particular drugs to prevent fraud, abuse, overuse, and possible
859 dangerous drug interactions. The Pharmaceutical and Therapeutics
860 Committee shall make recommendations to the agency on drugs for
861 which prior authorization is required. The agency shall inform
862 the Pharmaceutical and Therapeutics Committee of its decisions
863 regarding drugs subject to prior authorization. The agency is
864 authorized to limit the entities it contracts with or enrolls as
865 Medicaid providers by developing a provider network through
866 provider credentialing. The agency may competitively bid single-
867 source-provider contracts if procurement of goods or services
868 results in demonstrated cost savings to the state without

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869 limiting access to care. The agency may limit its network based
870 on the assessment of beneficiary access to care, provider
871 availability, provider quality standards, time and distance
872 standards for access to care, the cultural competence of the
873 provider network, demographic characteristics of Medicaid
874 beneficiaries, practice and provider-to-beneficiary standards,
875 appointment wait times, beneficiary use of services, provider
876 turnover, provider profiling, provider licensure history,
877 previous program integrity investigations and findings, peer
878 review, provider Medicaid policy and billing compliance records,
879 clinical and medical record audits, and other factors. Providers
880 are ~~shall~~ not ~~be~~ entitled to enrollment in the Medicaid provider
881 network. The agency shall determine instances in which allowing
882 Medicaid beneficiaries to purchase durable medical equipment and
883 other goods is less expensive to the Medicaid program than long-
884 term rental of the equipment or goods. The agency may establish
885 rules to facilitate purchases in lieu of long-term rentals in
886 order to protect against fraud and abuse in the Medicaid program
887 as defined in s. 409.913. The agency may seek federal waivers
888 necessary to administer these policies.

889 (1) The agency shall work with the Department of Children
890 and Family Services to ensure access of children and families in
891 the child protection system to needed and appropriate mental
892 health and substance abuse services. This subsection expires
893 October 1, 2014.

894 (2) The agency may enter into agreements with appropriate
895 agents of other state agencies or of any agency of the Federal
896 Government and accept such duties in respect to social welfare

897 or public aid as may be necessary to implement the provisions of
 898 Title XIX of the Social Security Act and ss. 409.901-409.920.
 899 This subsection expires October 1, 2016.

900 (3) The agency may contract with health maintenance
 901 organizations certified pursuant to part I of chapter 641 for
 902 the provision of services to recipients. This subsection expires
 903 October 1, 2014.

904 (4) The agency may contract with:

905 (a) An entity that provides no prepaid health care
 906 services other than Medicaid services under contract with the
 907 agency and which is owned and operated by a county, county
 908 health department, or county-owned and operated hospital to
 909 provide health care services on a prepaid or fixed-sum basis to
 910 recipients, which entity may provide such prepaid services
 911 either directly or through arrangements with other providers.
 912 Such prepaid health care services entities must be licensed
 913 under parts I and III of chapter 641. An entity recognized under
 914 this paragraph which demonstrates to the satisfaction of the
 915 Office of Insurance Regulation of the Financial Services
 916 Commission that it is backed by the full faith and credit of the
 917 county in which it is located may be exempted from s. 641.225.
 918 This paragraph expires October 1, 2014.

919 (b) An entity that is providing comprehensive behavioral
 920 health care services to certain Medicaid recipients through a
 921 capitated, prepaid arrangement pursuant to the federal waiver
 922 provided for by s. 409.905(5). Such entity must be licensed
 923 under chapter 624, chapter 636, or chapter 641, or authorized
 924 under paragraph (c) or paragraph (d), and must possess the

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925 clinical systems and operational competence to manage risk and
926 provide comprehensive behavioral health care to Medicaid
927 recipients. As used in this paragraph, the term "comprehensive
928 behavioral health care services" means covered mental health and
929 substance abuse treatment services that are available to
930 Medicaid recipients. The secretary of the Department of Children
931 and Family Services shall approve provisions of procurements
932 related to children in the department's care or custody before
933 enrolling such children in a prepaid behavioral health plan. Any
934 contract awarded under this paragraph must be competitively
935 procured. In developing the behavioral health care prepaid plan
936 procurement document, the agency shall ensure that the
937 procurement document requires the contractor to develop and
938 implement a plan to ensure compliance with s. 394.4574 related
939 to services provided to residents of licensed assisted living
940 facilities that hold a limited mental health license. Except as
941 provided in subparagraph 5. ~~8.~~, and except in counties where the
942 Medicaid managed care pilot program is authorized pursuant to s.
943 409.91211, the agency shall seek federal approval to contract
944 with a single entity meeting these requirements to provide
945 comprehensive behavioral health care services to all Medicaid
946 recipients not enrolled in a Medicaid managed care plan
947 authorized under s. 409.91211, a provider service network
948 authorized under paragraph (d), or a Medicaid health maintenance
949 organization in an AHCA area. In an AHCA area where the Medicaid
950 managed care pilot program is authorized pursuant to s.
951 409.91211 in one or more counties, the agency may procure a
952 contract with a single entity to serve the remaining counties as

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953 an AHCA area or the remaining counties may be included with an
954 adjacent AHCA area and are subject to this paragraph. Each
955 entity must offer a sufficient choice of providers in its
956 network to ensure recipient access to care and the opportunity
957 to select a provider with whom they are satisfied. The network
958 shall include all public mental health hospitals. To ensure
959 unimpaired access to behavioral health care services by Medicaid
960 recipients, all contracts issued pursuant to this paragraph must
961 require 80 percent of the capitation paid to the managed care
962 plan, including health maintenance organizations and capitated
963 provider service networks, to be expended for the provision of
964 behavioral health care services. If the managed care plan
965 expends less than 80 percent of the capitation paid for the
966 provision of behavioral health care services, the difference
967 shall be returned to the agency. The agency shall provide the
968 plan with a certification letter indicating the amount of
969 capitation paid during each calendar year for behavioral health
970 care services pursuant to this section. The agency may reimburse
971 for substance abuse treatment services on a fee-for-service
972 basis until the agency finds that adequate funds are available
973 for capitated, prepaid arrangements.

974 1. ~~By January 1, 2001,~~ The agency shall modify the
975 contracts with the entities providing comprehensive inpatient
976 and outpatient mental health care services to Medicaid
977 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
978 Counties, to include substance abuse treatment services.

979 2. ~~By July 1, 2003, the agency and the Department of~~
980 ~~Children and Family Services shall execute a written agreement~~

981 ~~that requires collaboration and joint development of all policy,~~
 982 ~~budgets, procurement documents, contracts, and monitoring plans~~
 983 ~~that have an impact on the state and Medicaid community mental~~
 984 ~~health and targeted case management programs.~~

985 2.3. Except as provided in subparagraph 5. 8., ~~by July 1,~~
 986 ~~2006,~~ the agency and the Department of Children and Family
 987 Services shall contract with managed care entities in each AHCA
 988 area except area 6 or arrange to provide comprehensive inpatient
 989 and outpatient mental health and substance abuse services
 990 through capitated prepaid arrangements to all Medicaid
 991 recipients who are eligible to participate in such plans under
 992 federal law and regulation. In AHCA areas where eligible
 993 individuals number less than 150,000, the agency shall contract
 994 with a single managed care plan to provide comprehensive
 995 behavioral health services to all recipients who are not
 996 enrolled in a Medicaid health maintenance organization, a
 997 provider service network authorized under paragraph (d), or a
 998 Medicaid capitated managed care plan authorized under s.
 999 409.91211. The agency may contract with more than one
 1000 comprehensive behavioral health provider to provide care to
 1001 recipients who are not enrolled in a Medicaid capitated managed
 1002 care plan authorized under s. 409.91211, a provider service
 1003 network authorized under paragraph (d), or a Medicaid health
 1004 maintenance organization in AHCA areas where the eligible
 1005 population exceeds 150,000. In an AHCA area where the Medicaid
 1006 managed care pilot program is authorized pursuant to s.
 1007 409.91211 in one or more counties, the agency may procure a
 1008 contract with a single entity to serve the remaining counties as

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1009 an AHCA area or the remaining counties may be included with an
 1010 adjacent AHCA area and shall be subject to this paragraph.
 1011 Contracts for comprehensive behavioral health providers awarded
 1012 pursuant to this section shall be competitively procured. Both
 1013 for-profit and not-for-profit corporations are eligible to
 1014 compete. Managed care plans contracting with the agency under
 1015 subsection (3) or paragraph (d), shall provide and receive
 1016 payment for the same comprehensive behavioral health benefits as
 1017 provided in AHCA rules, including handbooks incorporated by
 1018 reference. In AHCA area 11, the agency shall contract with at
 1019 least two comprehensive behavioral health care providers to
 1020 provide behavioral health care to recipients in that area who
 1021 are enrolled in, or assigned to, the MediPass program. One of
 1022 the behavioral health care contracts must be with the existing
 1023 provider service network pilot project, as described in
 1024 paragraph (d), for the purpose of demonstrating the cost-
 1025 effectiveness of the provision of quality mental health services
 1026 through a public hospital-operated managed care model. Payment
 1027 shall be at an agreed-upon capitated rate to ensure cost
 1028 savings. Of the recipients in area 11 who are assigned to
 1029 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
 1030 MediPass-enrolled recipients shall be assigned to the existing
 1031 provider service network in area 11 for their behavioral care.

1032 ~~4. By October 1, 2003, the agency and the department shall~~
 1033 ~~submit a plan to the Governor, the President of the Senate, and~~
 1034 ~~the Speaker of the House of Representatives which provides for~~
 1035 ~~the full implementation of capitated prepaid behavioral health~~
 1036 ~~care in all areas of the state.~~

1037 a. ~~Implementation shall begin in 2003 in those AHCA areas~~
 1038 ~~of the state where the agency is able to establish sufficient~~
 1039 ~~capitation rates.~~

1040 b. ~~If the agency determines that the proposed capitation~~
 1041 ~~rate in any area is insufficient to provide appropriate~~
 1042 ~~services, the agency may adjust the capitation rate to ensure~~
 1043 ~~that care will be available. The agency and the department may~~
 1044 ~~use existing general revenue to address any additional required~~
 1045 ~~match but may not over-obligate existing funds on an annualized~~
 1046 ~~basis.~~

1047 c. ~~Subject to any limitations provided in the General~~
 1048 ~~Appropriations Act, the agency, in compliance with appropriate~~
 1049 ~~federal authorization, shall develop policies and procedures~~
 1050 ~~that allow for certification of local and state funds.~~

1051 3.5. ~~Children residing in a statewide inpatient~~
 1052 ~~psychiatric program, or in a Department of Juvenile Justice or a~~
 1053 ~~Department of Children and Family Services residential program~~
 1054 ~~approved as a Medicaid behavioral health overlay services~~
 1055 ~~provider may not be included in a behavioral health care prepaid~~
 1056 ~~health plan or any other Medicaid managed care plan pursuant to~~
 1057 ~~this paragraph.~~

1058 ~~6. In converting to a prepaid system of delivery, the~~
 1059 ~~agency shall in its procurement document require an entity~~
 1060 ~~providing only comprehensive behavioral health care services to~~
 1061 ~~prevent the displacement of indigent care patients by enrollees~~
 1062 ~~in the Medicaid prepaid health plan providing behavioral health~~
 1063 ~~care services from facilities receiving state funding to provide~~
 1064 ~~indigent behavioral health care, to facilities licensed under~~

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1065 ~~chapter 395 which do not receive state funding for indigent~~
 1066 ~~behavioral health care, or reimburse the unsubsidized facility~~
 1067 ~~for the cost of behavioral health care provided to the displaced~~
 1068 ~~indigent care patient.~~

1069 4.7. Traditional community mental health providers under
 1070 contract with the Department of Children and Family Services
 1071 pursuant to part IV of chapter 394, child welfare providers
 1072 under contract with the Department of Children and Family
 1073 Services in areas 1 and 6, and inpatient mental health providers
 1074 licensed pursuant to chapter 395 must be offered an opportunity
 1075 to accept or decline a contract to participate in any provider
 1076 network for prepaid behavioral health services.

1077 5.8. All Medicaid-eligible children, except children in
 1078 area 1 and children in Highlands County, Hardee County, Polk
 1079 County, or Manatee County of area 6, that are open for child
 1080 welfare services in the HomeSafeNet system, shall receive their
 1081 behavioral health care services through a specialty prepaid plan
 1082 operated by community-based lead agencies through a single
 1083 agency or formal agreements among several agencies. The
 1084 specialty prepaid plan must result in savings to the state
 1085 comparable to savings achieved in other Medicaid managed care
 1086 and prepaid programs. Such plan must provide mechanisms to
 1087 maximize state and local revenues. The specialty prepaid plan
 1088 shall be developed by the agency and the Department of Children
 1089 and Family Services. The agency may seek federal waivers to
 1090 implement this initiative. Medicaid-eligible children whose
 1091 cases are open for child welfare services in the HomeSafeNet
 1092 system and who reside in AHCA area 10 are exempt from the

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1093 specialty prepaid plan upon the development of a service
 1094 delivery mechanism for children who reside in area 10 as
 1095 specified in s. 409.91211(3) (dd).

1096
 1097 This paragraph expires October 1, 2014.

1098 (c) A federally qualified health center or an entity owned
 1099 by one or more federally qualified health centers or an entity
 1100 owned by other migrant and community health centers receiving
 1101 non-Medicaid financial support from the Federal Government to
 1102 provide health care services on a prepaid or fixed-sum basis to
 1103 recipients. A federally qualified health center or an entity
 1104 that is owned by one or more federally qualified health centers
 1105 and is reimbursed by the agency on a prepaid basis is exempt
 1106 from parts I and III of chapter 641, but must comply with the
 1107 solvency requirements in s. 641.2261(2) and meet the appropriate
 1108 requirements governing financial reserve, quality assurance, and
 1109 patients' rights established by the agency. This paragraph
 1110 expires October 1, 2014.

1111 (d)1. A provider service network may be reimbursed on a
 1112 fee-for-service or prepaid basis. Prepaid provider service
 1113 networks shall receive per-member, per-month payments. A
 1114 provider service network that does not choose to be a prepaid
 1115 plan shall receive fee-for-service rates with a shared savings
 1116 settlement. The fee-for-service option shall be available to a
 1117 provider service network only for the first 5 years of the
 1118 plan's operation or until the contract year beginning October 1,
 1119 2014, whichever is later. The agency shall annually conduct cost
 1120 reconciliations to determine the amount of cost savings achieved

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1121 by fee-for-service provider service networks for the dates of
1122 service in the period being reconciled. Only payments for
1123 covered services for dates of service within the reconciliation
1124 period and paid within 6 months after the last date of service
1125 in the reconciliation period shall be included. The agency shall
1126 perform the necessary adjustments for the inclusion of claims
1127 incurred but not reported within the reconciliation for claims
1128 that could be received and paid by the agency after the 6-month
1129 claims processing time lag. The agency shall provide the results
1130 of the reconciliations to the fee-for-service provider service
1131 networks within 45 days after the end of the reconciliation
1132 period. The fee-for-service provider service networks shall
1133 review and provide written comments or a letter of concurrence
1134 to the agency within 45 days after receipt of the reconciliation
1135 results. This reconciliation shall be considered final.

1136 2. A provider service network which is reimbursed by the
1137 agency on a prepaid basis shall be exempt from parts I and III
1138 of chapter 641, but must comply with the solvency requirements
1139 in s. 641.2261(2) and meet appropriate financial reserve,
1140 quality assurance, and patient rights requirements as
1141 established by the agency.

1142 3. Medicaid recipients assigned to a provider service
1143 network shall be chosen equally from those who would otherwise
1144 have been assigned to prepaid plans and MediPass. The agency is
1145 authorized to seek federal Medicaid waivers as necessary to
1146 implement the provisions of this section. This subparagraph
1147 expires October 1, 2014. ~~Any contract previously awarded to a~~
1148 ~~provider service network operated by a hospital pursuant to this~~

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1149 ~~subsection shall remain in effect for a period of 3 years~~
1150 ~~following the current contract expiration date, regardless of~~
1151 ~~any contractual provisions to the contrary.~~

1152 4. A provider service network is a network established or
1153 organized and operated by a health care provider, or group of
1154 affiliated health care providers, including minority physician
1155 networks and emergency room diversion programs that meet the
1156 requirements of s. 409.91211, which provides a substantial
1157 proportion of the health care items and services under a
1158 contract directly through the provider or affiliated group of
1159 providers and may make arrangements with physicians or other
1160 health care professionals, health care institutions, or any
1161 combination of such individuals or institutions to assume all or
1162 part of the financial risk on a prospective basis for the
1163 provision of basic health services by the physicians, by other
1164 health professionals, or through the institutions. The health
1165 care providers must have a controlling interest in the governing
1166 body of the provider service network organization.

1167 (e) An entity that provides only comprehensive behavioral
1168 health care services to certain Medicaid recipients through an
1169 administrative services organization agreement. Such an entity
1170 must possess the clinical systems and operational competence to
1171 provide comprehensive health care to Medicaid recipients. As
1172 used in this paragraph, the term "comprehensive behavioral
1173 health care services" means covered mental health and substance
1174 abuse treatment services that are available to Medicaid
1175 recipients. Any contract awarded under this paragraph must be
1176 competitively procured. The agency must ensure that Medicaid

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1177 recipients have available the choice of at least two managed
1178 care plans for their behavioral health care services. This
1179 paragraph expires October 1, 2014.

1180 ~~(f) An entity that provides in-home physician services to~~
1181 ~~test the cost-effectiveness of enhanced home-based medical care~~
1182 ~~to Medicaid recipients with degenerative neurological diseases~~
1183 ~~and other diseases or disabling conditions associated with high~~
1184 ~~costs to Medicaid. The program shall be designed to serve very~~
1185 ~~disabled persons and to reduce Medicaid reimbursed costs for~~
1186 ~~inpatient, outpatient, and emergency department services. The~~
1187 ~~agency shall contract with vendors on a risk-sharing basis.~~

1188 ~~(g) Children's provider networks that provide care~~
1189 ~~coordination and care management for Medicaid-eligible pediatric~~
1190 ~~patients, primary care, authorization of specialty care, and~~
1191 ~~other urgent and emergency care through organized providers~~
1192 ~~designed to service Medicaid eligibles under age 18 and~~
1193 ~~pediatric emergency departments' diversion programs. The~~
1194 ~~networks shall provide after-hour operations, including evening~~
1195 ~~and weekend hours, to promote, when appropriate, the use of the~~
1196 ~~children's networks rather than hospital emergency departments.~~

1197 (f) ~~(h)~~ An entity authorized in s. 430.205 to contract with
1198 the agency and the Department of Elderly Affairs to provide
1199 health care and social services on a prepaid or fixed-sum basis
1200 to elderly recipients. Such prepaid health care services
1201 entities are exempt from the provisions of part I of chapter 641
1202 for the first 3 years of operation. An entity recognized under
1203 this paragraph that demonstrates to the satisfaction of the
1204 Office of Insurance Regulation that it is backed by the full

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1205 faith and credit of one or more counties in which it operates
 1206 may be exempted from s. 641.225. This paragraph expires October
 1207 1, 2013.

1208 (g)(i) A Children's Medical Services Network, as defined
 1209 in s. 391.021. This paragraph expires October 1, 2014.

1210 ~~(5) The Agency for Health Care Administration, in~~
 1211 ~~partnership with the Department of Elderly Affairs, shall create~~
 1212 ~~an integrated, fixed-payment delivery program for Medicaid~~
 1213 ~~recipients who are 60 years of age or older or dually eligible~~
 1214 ~~for Medicare and Medicaid. The Agency for Health Care~~
 1215 ~~Administration shall implement the integrated program initially~~
 1216 ~~on a pilot basis in two areas of the state. The pilot areas~~
 1217 ~~shall be Area 7 and Area 11 of the Agency for Health Care~~
 1218 ~~Administration. Enrollment in the pilot areas shall be on a~~
 1219 ~~voluntary basis and in accordance with approved federal waivers~~
 1220 ~~and this section. The agency and its program contractors and~~
 1221 ~~providers shall not enroll any individual in the integrated~~
 1222 ~~program because the individual or the person legally responsible~~
 1223 ~~for the individual fails to choose to enroll in the integrated~~
 1224 ~~program. Enrollment in the integrated program shall be~~
 1225 ~~exclusively by affirmative choice of the eligible individual or~~
 1226 ~~by the person legally responsible for the individual. The~~
 1227 ~~integrated program must transfer all Medicaid services for~~
 1228 ~~eligible elderly individuals who choose to participate into an~~
 1229 ~~integrated care management model designed to serve Medicaid~~
 1230 ~~recipients in the community. The integrated program must combine~~
 1231 ~~all funding for Medicaid services provided to individuals who~~
 1232 ~~are 60 years of age or older or dually eligible for Medicare and~~

1233 ~~Medicaid into the integrated program, including funds for~~
 1234 ~~Medicaid home and community-based waiver services; all Medicaid~~
 1235 ~~services authorized in ss. 409.905 and 409.906, excluding funds~~
 1236 ~~for Medicaid nursing home services unless the agency is able to~~
 1237 ~~demonstrate how the integration of the funds will improve~~
 1238 ~~coordinated care for these services in a less costly manner; and~~
 1239 ~~Medicare coinsurance and deductibles for persons dually eligible~~
 1240 ~~for Medicaid and Medicare as prescribed in s. 409.908(13).~~

1241 ~~(a) Individuals who are 60 years of age or older or dually~~
 1242 ~~eligible for Medicare and Medicaid and enrolled in the~~
 1243 ~~developmental disabilities waiver program, the family and~~
 1244 ~~supported living waiver program, the project AIDS care waiver~~
 1245 ~~program, the traumatic brain injury and spinal cord injury~~
 1246 ~~waiver program, the consumer-directed care waiver program, and~~
 1247 ~~the program of all-inclusive care for the elderly program, and~~
 1248 ~~residents of institutional care facilities for the~~
 1249 ~~developmentally disabled, must be excluded from the integrated~~
 1250 ~~program.~~

1251 ~~(b) Managed care entities who meet or exceed the agency's~~
 1252 ~~minimum standards are eligible to operate the integrated~~
 1253 ~~program. Entities eligible to participate include managed care~~
 1254 ~~organizations licensed under chapter 641, including entities~~
 1255 ~~eligible to participate in the nursing home diversion program,~~
 1256 ~~other qualified providers as defined in s. 430.703(7), community~~
 1257 ~~care for the elderly lead agencies, and other state-certified~~
 1258 ~~community service networks that meet comparable standards as~~
 1259 ~~defined by the agency, in consultation with the Department of~~
 1260 ~~Elderly Affairs and the Office of Insurance Regulation, to be~~

1261 ~~financially solvent and able to take on financial risk for~~
 1262 ~~managed care. Community service networks that are certified~~
 1263 ~~pursuant to the comparable standards defined by the agency are~~
 1264 ~~not required to be licensed under chapter 641. Managed care~~
 1265 ~~entities who operate the integrated program shall be subject to~~
 1266 ~~s. 408.7056. Eligible entities shall choose to serve enrollees~~
 1267 ~~who are dually eligible for Medicare and Medicaid, enrollees who~~
 1268 ~~are 60 years of age or older, or both.~~

1269 ~~(c) The agency must ensure that the capitation-rate-~~
 1270 ~~setting methodology for the integrated program is actuarially~~
 1271 ~~sound and reflects the intent to provide quality care in the~~
 1272 ~~least restrictive setting. The agency must also require~~
 1273 ~~integrated-program providers to develop a credentialing system~~
 1274 ~~for service providers and to contract with all Gold Seal nursing~~
 1275 ~~homes, where feasible, and exclude, where feasible, chronically~~
 1276 ~~poor-performing facilities and providers as defined by the~~
 1277 ~~agency. The integrated program must develop and maintain an~~
 1278 ~~informal provider grievance system that addresses provider~~
 1279 ~~payment and contract problems. The agency shall also establish a~~
 1280 ~~formal grievance system to address those issues that were not~~
 1281 ~~resolved through the informal grievance system. The integrated~~
 1282 ~~program must provide that if the recipient resides in a~~
 1283 ~~noncontracted residential facility licensed under chapter 400 or~~
 1284 ~~chapter 429 at the time of enrollment in the integrated program,~~
 1285 ~~the recipient must be permitted to continue to reside in the~~
 1286 ~~noncontracted facility as long as the recipient desires. The~~
 1287 ~~integrated program must also provide that, in the absence of a~~
 1288 ~~contract between the integrated program provider and the~~

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1289 ~~residential facility licensed under chapter 400 or chapter 429,~~
1290 ~~current Medicaid rates must prevail. The integrated program~~
1291 ~~provider must ensure that electronic nursing home claims that~~
1292 ~~contain sufficient information for processing are paid within 10~~
1293 ~~business days after receipt. Alternately, the integrated program~~
1294 ~~provider may establish a capitated payment mechanism to~~
1295 ~~prospectively pay nursing homes at the beginning of each month.~~
1296 ~~The agency and the Department of Elderly Affairs must jointly~~
1297 ~~develop procedures to manage the services provided through the~~
1298 ~~integrated program in order to ensure quality and recipient~~
1299 ~~choice.~~

1300 ~~(d) The Office of Program Policy Analysis and Government~~
1301 ~~Accountability, in consultation with the Auditor General, shall~~
1302 ~~comprehensively evaluate the pilot project for the integrated,~~
1303 ~~fixed payment delivery program for Medicaid recipients created~~
1304 ~~under this subsection. The evaluation shall begin as soon as~~
1305 ~~Medicaid recipients are enrolled in the managed care pilot~~
1306 ~~program plans and shall continue for 24 months thereafter. The~~
1307 ~~evaluation must include assessments of each managed care plan in~~
1308 ~~the integrated program with regard to cost savings; consumer~~
1309 ~~education, choice, and access to services; coordination of care;~~
1310 ~~and quality of care. The evaluation must describe administrative~~
1311 ~~or legal barriers to the implementation and operation of the~~
1312 ~~pilot program and include recommendations regarding statewide~~
1313 ~~expansion of the pilot program. The office shall submit its~~
1314 ~~evaluation report to the Governor, the President of the Senate,~~
1315 ~~and the Speaker of the House of Representatives no later than~~
1316 ~~December 31, 2009.~~

1317 ~~(e) The agency may seek federal waivers or Medicaid state~~
 1318 ~~plan amendments and adopt rules as necessary to administer the~~
 1319 ~~integrated program. The agency may implement the approved~~
 1320 ~~federal waivers and other provisions as specified in this~~
 1321 ~~subsection.~~

1322 ~~(f) The implementation of the integrated, fixed payment~~
 1323 ~~delivery program created under this subsection is subject to an~~
 1324 ~~appropriation in the General Appropriations Act.~~

1325 (5)~~(6)~~ The agency may contract with any public or private
 1326 entity otherwise authorized by this section on a prepaid or
 1327 fixed-sum basis for the provision of health care services to
 1328 recipients. An entity may provide prepaid services to
 1329 recipients, either directly or through arrangements with other
 1330 entities, if each entity involved in providing services:

1331 (a) Is organized primarily for the purpose of providing
 1332 health care or other services of the type regularly offered to
 1333 Medicaid recipients;

1334 (b) Ensures that services meet the standards set by the
 1335 agency for quality, appropriateness, and timeliness;

1336 (c) Makes provisions satisfactory to the agency for
 1337 insolvency protection and ensures that neither enrolled Medicaid
 1338 recipients nor the agency will be liable for the debts of the
 1339 entity;

1340 (d) Submits to the agency, if a private entity, a
 1341 financial plan that the agency finds to be fiscally sound and
 1342 that provides for working capital in the form of cash or
 1343 equivalent liquid assets excluding revenues from Medicaid
 1344 premium payments equal to at least the first 3 months of

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1345 | operating expenses or \$200,000, whichever is greater;

1346 | (e) Furnishes evidence satisfactory to the agency of
 1347 | adequate liability insurance coverage or an adequate plan of
 1348 | self-insurance to respond to claims for injuries arising out of
 1349 | the furnishing of health care;

1350 | (f) Provides, through contract or otherwise, for periodic
 1351 | review of its medical facilities and services, as required by
 1352 | the agency; and

1353 | (g) Provides organizational, operational, financial, and
 1354 | other information required by the agency.

1355 |

1356 | This subsection expires October 1, 2014.

1357 | ~~(6)-(7)~~ The agency may contract on a prepaid or fixed-sum
 1358 | basis with any health insurer that:

1359 | (a) Pays for health care services provided to enrolled
 1360 | Medicaid recipients in exchange for a premium payment paid by
 1361 | the agency;

1362 | (b) Assumes the underwriting risk; and

1363 | (c) Is organized and licensed under applicable provisions
 1364 | of the Florida Insurance Code and is currently in good standing
 1365 | with the Office of Insurance Regulation.

1366 |

1367 | This subsection expires October 1, 2014.

1368 | ~~(7)-(8)-(a)~~ The agency may contract on a prepaid or fixed-
 1369 | sum basis with an exclusive provider organization to provide
 1370 | health care services to Medicaid recipients provided that the
 1371 | exclusive provider organization meets applicable managed care
 1372 | plan requirements in this section, ss. 409.9122, 409.9123,

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1373 409.9128, and 627.6472, and other applicable provisions of law.
 1374 This subsection expires October 1, 2014.

1375 ~~(b) For a period of no longer than 24 months after the~~
 1376 ~~effective date of this paragraph, when a member of an exclusive~~
 1377 ~~provider organization that is contracted by the agency to~~
 1378 ~~provide health care services to Medicaid recipients in rural~~
 1379 ~~areas without a health maintenance organization obtains services~~
 1380 ~~from a provider that participates in the Medicaid program in~~
 1381 ~~this state, the provider shall be paid in accordance with the~~
 1382 ~~appropriate fee schedule for services provided to eligible~~
 1383 ~~Medicaid recipients. The agency may seek waiver authority to~~
 1384 ~~implement this paragraph.~~

1385 (8)-(9) The Agency for Health Care Administration may
 1386 provide cost-effective purchasing of chiropractic services on a
 1387 fee-for-service basis to Medicaid recipients through
 1388 arrangements with a statewide chiropractic preferred provider
 1389 organization incorporated in this state as a not-for-profit
 1390 corporation. The agency shall ensure that the benefit limits and
 1391 prior authorization requirements in the current Medicaid program
 1392 shall apply to the services provided by the chiropractic
 1393 preferred provider organization. This subsection expires October
 1394 1, 2014.

1395 (9)-(10) The agency shall not contract on a prepaid or
 1396 fixed-sum basis for Medicaid services with an entity which knows
 1397 or reasonably should know that any officer, director, agent,
 1398 managing employee, or owner of stock or beneficial interest in
 1399 excess of 5 percent common or preferred stock, or the entity
 1400 itself, has been found guilty of, regardless of adjudication, or

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1401 entered a plea of nolo contendere, or guilty, to:

1402 (a) Fraud;

1403 (b) Violation of federal or state antitrust statutes,
 1404 including those proscribing price fixing between competitors and
 1405 the allocation of customers among competitors;

1406 (c) Commission of a felony involving embezzlement, theft,
 1407 forgery, income tax evasion, bribery, falsification or
 1408 destruction of records, making false statements, receiving
 1409 stolen property, making false claims, or obstruction of justice;
 1410 or

1411 (d) Any crime in any jurisdiction which directly relates
 1412 to the provision of health services on a prepaid or fixed-sum
 1413 basis.

1414

1415 This subsection expires October 1, 2014.

1416 (10)~~(11)~~ The agency, after notifying the Legislature, may
 1417 apply for waivers of applicable federal laws and regulations as
 1418 necessary to implement more appropriate systems of health care
 1419 for Medicaid recipients and reduce the cost of the Medicaid
 1420 program to the state and federal governments and shall implement
 1421 such programs, after legislative approval, within a reasonable
 1422 period of time after federal approval. These programs must be
 1423 designed primarily to reduce the need for inpatient care,
 1424 custodial care and other long-term or institutional care, and
 1425 other high-cost services. Prior to seeking legislative approval
 1426 of such a waiver as authorized by this subsection, the agency
 1427 shall provide notice and an opportunity for public comment.
 1428 Notice shall be provided to all persons who have made requests

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1429 of the agency for advance notice and shall be published in the
1430 Florida Administrative Weekly not less than 28 days prior to the
1431 intended action. This subsection expires October 1, 2016.

1432 (11)~~(12)~~ The agency shall establish a postpayment
1433 utilization control program designed to identify recipients who
1434 may inappropriately overuse or underuse Medicaid services and
1435 shall provide methods to correct such misuse. This subsection
1436 expires October 1, 2014.

1437 (12)~~(13)~~ The agency shall develop and provide coordinated
1438 systems of care for Medicaid recipients and may contract with
1439 public or private entities to develop and administer such
1440 systems of care among public and private health care providers
1441 in a given geographic area. This subsection expires October 1,
1442 2014.

1443 (13)~~(14)~~~~(a)~~ The agency shall operate or contract for the
1444 operation of utilization management and incentive systems
1445 designed to encourage cost-effective use of services and to
1446 eliminate services that are medically unnecessary. The agency
1447 shall track Medicaid provider prescription and billing patterns
1448 and evaluate them against Medicaid medical necessity criteria
1449 and coverage and limitation guidelines adopted by rule. Medical
1450 necessity determination requires that service be consistent with
1451 symptoms or confirmed diagnosis of illness or injury under
1452 treatment and not in excess of the patient's needs. The agency
1453 shall conduct reviews of provider exceptions to peer group norms
1454 and shall, using statistical methodologies, provider profiling,
1455 and analysis of billing patterns, detect and investigate
1456 abnormal or unusual increases in billing or payment of claims

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1457 for Medicaid services and medically unnecessary provision of
1458 services. Providers that demonstrate a pattern of submitting
1459 claims for medically unnecessary services shall be referred to
1460 the Medicaid program integrity unit for investigation. In its
1461 annual report, required in s. 409.913, the agency shall report
1462 on its efforts to control overutilization as described in this
1463 subsection paragraph. This subsection expires October 1, 2014.

1464 ~~(b) The agency shall develop a procedure for determining~~
1465 ~~whether health care providers and service vendors can provide~~
1466 ~~the Medicaid program using a business case that demonstrates~~
1467 ~~whether a particular good or service can offset the cost of~~
1468 ~~providing the good or service in an alternative setting or~~
1469 ~~through other means and therefore should receive a higher~~
1470 ~~reimbursement. The business case must include, but need not be~~
1471 ~~limited to:~~

1472 ~~1. A detailed description of the good or service to be~~
1473 ~~provided, a description and analysis of the agency's current~~
1474 ~~performance of the service, and a rationale documenting how~~
1475 ~~providing the service in an alternative setting would be in the~~
1476 ~~best interest of the state, the agency, and its clients.~~

1477 ~~2. A cost-benefit analysis documenting the estimated~~
1478 ~~specific direct and indirect costs, savings, performance~~
1479 ~~improvements, risks, and qualitative and quantitative benefits~~
1480 ~~involved in or resulting from providing the service. The cost-~~
1481 ~~benefit analysis must include a detailed plan and timeline~~
1482 ~~identifying all actions that must be implemented to realize~~
1483 ~~expected benefits. The Secretary of Health Care Administration~~
1484 ~~shall verify that all costs, savings, and benefits are valid and~~

1485 ~~achievable.~~

1486 ~~(c) If the agency determines that the increased~~
 1487 ~~reimbursement is cost-effective, the agency shall recommend a~~
 1488 ~~change in the reimbursement schedule for that particular good or~~
 1489 ~~service. If, within 12 months after implementing any rate change~~
 1490 ~~under this procedure, the agency determines that costs were not~~
 1491 ~~offset by the increased reimbursement schedule, the agency may~~
 1492 ~~revert to the former reimbursement schedule for the particular~~
 1493 ~~good or service.~~

1494 (14)~~(15)~~ (a) The agency shall operate the Comprehensive
 1495 Assessment and Review for Long-Term Care Services (CARES)
 1496 nursing facility preadmission screening program to ensure that
 1497 Medicaid payment for nursing facility care is made only for
 1498 individuals whose conditions require such care and to ensure
 1499 that long-term care services are provided in the setting most
 1500 appropriate to the needs of the person and in the most
 1501 economical manner possible. The CARES program shall also ensure
 1502 that individuals participating in Medicaid home and community-
 1503 based waiver programs meet criteria for those programs,
 1504 consistent with approved federal waivers.

1505 (b) The agency shall operate the CARES program through an
 1506 interagency agreement with the Department of Elderly Affairs.
 1507 The agency, in consultation with the Department of Elderly
 1508 Affairs, may contract for any function or activity of the CARES
 1509 program, including any function or activity required by 42
 1510 C.F.R. part 483.20, relating to preadmission screening and
 1511 resident review.

1512 (c) Prior to making payment for nursing facility services

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1513 | for a Medicaid recipient, the agency must verify that the
1514 | nursing facility preadmission screening program has determined
1515 | that the individual requires nursing facility care and that the
1516 | individual cannot be safely served in community-based programs.
1517 | The nursing facility preadmission screening program shall refer
1518 | a Medicaid recipient to a community-based program if the
1519 | individual could be safely served at a lower cost and the
1520 | recipient chooses to participate in such program. For
1521 | individuals whose nursing home stay is initially funded by
1522 | Medicare and Medicare coverage is being terminated for lack of
1523 | progress towards rehabilitation, CARES staff shall consult with
1524 | the person making the determination of progress toward
1525 | rehabilitation to ensure that the recipient is not being
1526 | inappropriately disqualified from Medicare coverage. If, in
1527 | their professional judgment, CARES staff believes that a
1528 | Medicare beneficiary is still making progress toward
1529 | rehabilitation, they may assist the Medicare beneficiary with an
1530 | appeal of the disqualification from Medicare coverage. The use
1531 | of CARES teams to review Medicare denials for coverage under
1532 | this section is authorized only if it is determined that such
1533 | reviews qualify for federal matching funds through Medicaid. The
1534 | agency shall seek or amend federal waivers as necessary to
1535 | implement this section.

1536 | (d) For the purpose of initiating immediate prescreening
1537 | and diversion assistance for individuals residing in nursing
1538 | homes and in order to make families aware of alternative long-
1539 | term care resources so that they may choose a more cost-
1540 | effective setting for long-term placement, CARES staff shall

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1541 | conduct an assessment and review of a sample of individuals
 1542 | whose nursing home stay is expected to exceed 20 days,
 1543 | regardless of the initial funding source for the nursing home
 1544 | placement. CARES staff shall provide counseling and referral
 1545 | services to these individuals regarding choosing appropriate
 1546 | long-term care alternatives. This paragraph does not apply to
 1547 | continuing care facilities licensed under chapter 651 or to
 1548 | retirement communities that provide a combination of nursing
 1549 | home, independent living, and other long-term care services.

1550 | (e) By January 15 of each year, the agency shall submit a
 1551 | report to the Legislature describing the operations of the CARES
 1552 | program. The report must describe:

1553 | 1. Rate of diversion to community alternative programs;

1554 | 2. CARES program staffing needs to achieve additional
 1555 | diversions;

1556 | 3. Reasons the program is unable to place individuals in
 1557 | less restrictive settings when such individuals desired such
 1558 | services and could have been served in such settings;

1559 | 4. Barriers to appropriate placement, including barriers
 1560 | due to policies or operations of other agencies or state-funded
 1561 | programs; and

1562 | 5. Statutory changes necessary to ensure that individuals
 1563 | in need of long-term care services receive care in the least
 1564 | restrictive environment.

1565 | (f) The Department of Elderly Affairs shall track
 1566 | individuals over time who are assessed under the CARES program
 1567 | and who are diverted from nursing home placement. By January 15
 1568 | of each year, the department shall submit to the Legislature a

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1569 longitudinal study of the individuals who are diverted from
 1570 nursing home placement. The study must include:

1571 1. The demographic characteristics of the individuals
 1572 assessed and diverted from nursing home placement, including,
 1573 but not limited to, age, race, gender, frailty, caregiver
 1574 status, living arrangements, and geographic location;

1575 2. A summary of community services provided to individuals
 1576 for 1 year after assessment and diversion;

1577 3. A summary of inpatient hospital admissions for
 1578 individuals who have been diverted; and

1579 4. A summary of the length of time between diversion and
 1580 subsequent entry into a nursing home or death.

1581

1582 This subsection expires October 1, 2013.

1583 (15)~~(16)~~(a) The agency shall identify health care
 1584 utilization and price patterns within the Medicaid program which
 1585 are not cost-effective or medically appropriate and assess the
 1586 effectiveness of new or alternate methods of providing and
 1587 monitoring service, and may implement such methods as it
 1588 considers appropriate. Such methods may include disease
 1589 management initiatives, an integrated and systematic approach
 1590 for managing the health care needs of recipients who are at risk
 1591 of or diagnosed with a specific disease by using best practices,
 1592 prevention strategies, clinical-practice improvement, clinical
 1593 interventions and protocols, outcomes research, information
 1594 technology, and other tools and resources to reduce overall
 1595 costs and improve measurable outcomes.

1596 (b) The responsibility of the agency under this subsection

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1597 shall include the development of capabilities to identify actual
1598 and optimal practice patterns; patient and provider educational
1599 initiatives; methods for determining patient compliance with
1600 prescribed treatments; fraud, waste, and abuse prevention and
1601 detection programs; and beneficiary case management programs.

1602 1. The practice pattern identification program shall
1603 evaluate practitioner prescribing patterns based on national and
1604 regional practice guidelines, comparing practitioners to their
1605 peer groups. The agency and its Drug Utilization Review Board
1606 shall consult with the Department of Health and a panel of
1607 practicing health care professionals consisting of the
1608 following: the Speaker of the House of Representatives and the
1609 President of the Senate shall each appoint three physicians
1610 licensed under chapter 458 or chapter 459; and the Governor
1611 shall appoint two pharmacists licensed under chapter 465 and one
1612 dentist licensed under chapter 466 who is an oral surgeon. Terms
1613 of the panel members shall expire at the discretion of the
1614 appointing official. The advisory panel shall be responsible for
1615 evaluating treatment guidelines and recommending ways to
1616 incorporate their use in the practice pattern identification
1617 program. Practitioners who are prescribing inappropriately or
1618 inefficiently, as determined by the agency, may have their
1619 prescribing of certain drugs subject to prior authorization or
1620 may be terminated from all participation in the Medicaid
1621 program.

1622 2. The agency shall also develop educational interventions
1623 designed to promote the proper use of medications by providers
1624 and beneficiaries.

1625 3. The agency shall implement a pharmacy fraud, waste, and
 1626 abuse initiative that may include a surety bond or letter of
 1627 credit requirement for participating pharmacies, enhanced
 1628 provider auditing practices, the use of additional fraud and
 1629 abuse software, recipient management programs for beneficiaries
 1630 inappropriately using their benefits, and other steps that will
 1631 eliminate provider and recipient fraud, waste, and abuse. The
 1632 initiative shall address enforcement efforts to reduce the
 1633 number and use of counterfeit prescriptions.

1634 4. By September 30, 2002, the agency shall contract with
 1635 an entity in the state to implement a wireless handheld clinical
 1636 pharmacology drug information database for practitioners. The
 1637 initiative shall be designed to enhance the agency's efforts to
 1638 reduce fraud, abuse, and errors in the prescription drug benefit
 1639 program and to otherwise further the intent of this paragraph.

1640 5. By April 1, 2006, the agency shall contract with an
 1641 entity to design a database of clinical utilization information
 1642 or electronic medical records for Medicaid providers. This
 1643 system must be web-based and allow providers to review on a
 1644 real-time basis the utilization of Medicaid services, including,
 1645 but not limited to, physician office visits, inpatient and
 1646 outpatient hospitalizations, laboratory and pathology services,
 1647 radiological and other imaging services, dental care, and
 1648 patterns of dispensing prescription drugs in order to coordinate
 1649 care and identify potential fraud and abuse.

1650 6. The agency may apply for any federal waivers needed to
 1651 administer this paragraph.

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1653 This subsection expires October 1, 2014.

1654 (16)~~(17)~~ An entity contracting on a prepaid or fixed-sum
 1655 basis shall meet the surplus requirements of s. 641.225. If an
 1656 entity's surplus falls below an amount equal to the surplus
 1657 requirements of s. 641.225, the agency shall prohibit the entity
 1658 from engaging in marketing and preenrollment activities, shall
 1659 cease to process new enrollments, and may not renew the entity's
 1660 contract until the required balance is achieved. The
 1661 requirements of this subsection do not apply:

1662 (a) Where a public entity agrees to fund any deficit
 1663 incurred by the contracting entity; or

1664 (b) Where the entity's performance and obligations are
 1665 guaranteed in writing by a guaranteeing organization which:

1666 1. Has been in operation for at least 5 years and has
 1667 assets in excess of \$50 million; or

1668 2. Submits a written guarantee acceptable to the agency
 1669 which is irrevocable during the term of the contracting entity's
 1670 contract with the agency and, upon termination of the contract,
 1671 until the agency receives proof of satisfaction of all
 1672 outstanding obligations incurred under the contract.

1673

1674 This subsection expires October 1, 2014.

1675 (17)~~(18)~~ (a) The agency may require an entity contracting
 1676 on a prepaid or fixed-sum basis to establish a restricted
 1677 insolvency protection account with a federally guaranteed
 1678 financial institution licensed to do business in this state. The
 1679 entity shall deposit into that account 5 percent of the
 1680 capitation payments made by the agency each month until a

1681 maximum total of 2 percent of the total current contract amount
 1682 is reached. The restricted insolvency protection account may be
 1683 drawn upon with the authorized signatures of two persons
 1684 designated by the entity and two representatives of the agency.
 1685 If the agency finds that the entity is insolvent, the agency may
 1686 draw upon the account solely with the two authorized signatures
 1687 of representatives of the agency, and the funds may be disbursed
 1688 to meet financial obligations incurred by the entity under the
 1689 prepaid contract. If the contract is terminated, expired, or not
 1690 continued, the account balance must be released by the agency to
 1691 the entity upon receipt of proof of satisfaction of all
 1692 outstanding obligations incurred under this contract.

1693 (b) The agency may waive the insolvency protection account
 1694 requirement in writing when evidence is on file with the agency
 1695 of adequate insolvency insurance and reinsurance that will
 1696 protect enrollees if the entity becomes unable to meet its
 1697 obligations.

1698
 1699 This subsection expires October 1, 2014.

1700 (18)~~(19)~~ An entity that contracts with the agency on a
 1701 prepaid or fixed-sum basis for the provision of Medicaid
 1702 services shall reimburse any hospital or physician that is
 1703 outside the entity's authorized geographic service area as
 1704 specified in its contract with the agency, and that provides
 1705 services authorized by the entity to its members, at a rate
 1706 negotiated with the hospital or physician for the provision of
 1707 services or according to the lesser of the following:

1708 (a) The usual and customary charges made to the general

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1709 public by the hospital or physician; or

1710 (b) The Florida Medicaid reimbursement rate established
1711 for the hospital or physician.

1712

1713 This subsection expires October 1, 2014.

1714 ~~(19)-(20)~~ When a merger or acquisition of a Medicaid
1715 prepaid contractor has been approved by the Office of Insurance
1716 Regulation pursuant to s. 628.4615, the agency shall approve the
1717 assignment or transfer of the appropriate Medicaid prepaid
1718 contract upon request of the surviving entity of the merger or
1719 acquisition if the contractor and the other entity have been in
1720 good standing with the agency for the most recent 12-month
1721 period, unless the agency determines that the assignment or
1722 transfer would be detrimental to the Medicaid recipients or the
1723 Medicaid program. To be in good standing, an entity must not
1724 have failed accreditation or committed any material violation of
1725 the requirements of s. 641.52 and must meet the Medicaid
1726 contract requirements. For purposes of this section, a merger or
1727 acquisition means a change in controlling interest of an entity,
1728 including an asset or stock purchase. This subsection expires
1729 October 1, 2014.

1730 ~~(20)-(21)~~ Any entity contracting with the agency pursuant
1731 to this section to provide health care services to Medicaid
1732 recipients is prohibited from engaging in any of the following
1733 practices or activities:

1734 (a) Practices that are discriminatory, including, but not
1735 limited to, attempts to discourage participation on the basis of
1736 actual or perceived health status.

1737 (b) Activities that could mislead or confuse recipients,
 1738 or misrepresent the organization, its marketing representatives,
 1739 or the agency. Violations of this paragraph include, but are not
 1740 limited to:

1741 1. False or misleading claims that marketing
 1742 representatives are employees or representatives of the state or
 1743 county, or of anyone other than the entity or the organization
 1744 by whom they are reimbursed.

1745 2. False or misleading claims that the entity is
 1746 recommended or endorsed by any state or county agency, or by any
 1747 other organization which has not certified its endorsement in
 1748 writing to the entity.

1749 3. False or misleading claims that the state or county
 1750 recommends that a Medicaid recipient enroll with an entity.

1751 4. Claims that a Medicaid recipient will lose benefits
 1752 under the Medicaid program, or any other health or welfare
 1753 benefits to which the recipient is legally entitled, if the
 1754 recipient does not enroll with the entity.

1755 (c) Granting or offering of any monetary or other valuable
 1756 consideration for enrollment, except as authorized by subsection
 1757 (23) ~~(24)~~.

1758 (d) Door-to-door solicitation of recipients who have not
 1759 contacted the entity or who have not invited the entity to make
 1760 a presentation.

1761 (e) Solicitation of Medicaid recipients by marketing
 1762 representatives stationed in state offices unless approved and
 1763 supervised by the agency or its agent and approved by the
 1764 affected state agency when solicitation occurs in an office of

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1765 the state agency. The agency shall ensure that marketing
 1766 representatives stationed in state offices shall market their
 1767 managed care plans to Medicaid recipients only in designated
 1768 areas and in such a way as to not interfere with the recipients'
 1769 activities in the state office.

1770 (f) Enrollment of Medicaid recipients.

1771

1772 This subsection expires October 1, 2014.

1773 ~~(21)-(22)~~ The agency may impose a fine for a violation of
 1774 this section or the contract with the agency by a person or
 1775 entity that is under contract with the agency. With respect to
 1776 any nonwillful violation, such fine shall not exceed \$2,500 per
 1777 violation. In no event shall such fine exceed an aggregate
 1778 amount of \$10,000 for all nonwillful violations arising out of
 1779 the same action. With respect to any knowing and willful
 1780 violation of this section or the contract with the agency, the
 1781 agency may impose a fine upon the entity in an amount not to
 1782 exceed \$20,000 for each such violation. In no event shall such
 1783 fine exceed an aggregate amount of \$100,000 for all knowing and
 1784 willful violations arising out of the same action. This
 1785 subsection expires October 1, 2014.

1786 ~~(22)-(23)~~ A health maintenance organization or a person or
 1787 entity exempt from chapter 641 that is under contract with the
 1788 agency for the provision of health care services to Medicaid
 1789 recipients may not use or distribute marketing materials used to
 1790 solicit Medicaid recipients, unless such materials have been
 1791 approved by the agency. The provisions of this subsection do not
 1792 apply to general advertising and marketing materials used by a

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1793 health maintenance organization to solicit both non-Medicaid
 1794 subscribers and Medicaid recipients. This subsection expires
 1795 October 1, 2014.

1796 ~~(23)~~~~(24)~~ Upon approval by the agency, health maintenance
 1797 organizations and persons or entities exempt from chapter 641
 1798 that are under contract with the agency for the provision of
 1799 health care services to Medicaid recipients may be permitted
 1800 within the capitation rate to provide additional health benefits
 1801 that the agency has found are of high quality, are practicably
 1802 available, provide reasonable value to the recipient, and are
 1803 provided at no additional cost to the state. This subsection
 1804 expires October 1, 2014.

1805 ~~(24)~~~~(25)~~ The agency shall utilize the statewide health
 1806 maintenance organization complaint hotline for the purpose of
 1807 investigating and resolving Medicaid and prepaid health plan
 1808 complaints, maintaining a record of complaints and confirmed
 1809 problems, and receiving disenrollment requests made by
 1810 recipients. This subsection expires October 1, 2014.

1811 ~~(25)~~~~(26)~~ The agency shall require the publication of the
 1812 health maintenance organization's and the prepaid health plan's
 1813 consumer services telephone numbers and the "800" telephone
 1814 number of the statewide health maintenance organization
 1815 complaint hotline on each Medicaid identification card issued by
 1816 a health maintenance organization or prepaid health plan
 1817 contracting with the agency to serve Medicaid recipients and on
 1818 each subscriber handbook issued to a Medicaid recipient. This
 1819 subsection expires October 1, 2014.

1820 ~~(26)~~~~(27)~~ The agency shall establish a health care quality

1821 improvement system for those entities contracting with the
 1822 agency pursuant to this section, incorporating all the standards
 1823 and guidelines developed by the Medicaid Bureau of the Health
 1824 Care Financing Administration as a part of the quality assurance
 1825 reform initiative. The system shall include, but need not be
 1826 limited to, the following:

1827 (a) Guidelines for internal quality assurance programs,
 1828 including standards for:

- 1829 1. Written quality assurance program descriptions.
- 1830 2. Responsibilities of the governing body for monitoring,
 1831 evaluating, and making improvements to care.
- 1832 3. An active quality assurance committee.
- 1833 4. Quality assurance program supervision.
- 1834 5. Requiring the program to have adequate resources to
 1835 effectively carry out its specified activities.
- 1836 6. Provider participation in the quality assurance
 1837 program.
- 1838 7. Delegation of quality assurance program activities.
- 1839 8. Credentialing and recredentialing.
- 1840 9. Enrollee rights and responsibilities.
- 1841 10. Availability and accessibility to services and care.
- 1842 11. Ambulatory care facilities.
- 1843 12. Accessibility and availability of medical records, as
 1844 well as proper recordkeeping and process for record review.
- 1845 13. Utilization review.
- 1846 14. A continuity of care system.
- 1847 15. Quality assurance program documentation.
- 1848 16. Coordination of quality assurance activity with other

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1849 management activity.

1850 17. Delivering care to pregnant women and infants; to
 1851 elderly and disabled recipients, especially those who are at
 1852 risk of institutional placement; to persons with developmental
 1853 disabilities; and to adults who have chronic, high-cost medical
 1854 conditions.

1855 (b) Guidelines which require the entities to conduct
 1856 quality-of-care studies which:

1857 1. Target specific conditions and specific health service
 1858 delivery issues for focused monitoring and evaluation.

1859 2. Use clinical care standards or practice guidelines to
 1860 objectively evaluate the care the entity delivers or fails to
 1861 deliver for the targeted clinical conditions and health services
 1862 delivery issues.

1863 3. Use quality indicators derived from the clinical care
 1864 standards or practice guidelines to screen and monitor care and
 1865 services delivered.

1866 (c) Guidelines for external quality review of each
 1867 contractor which require: focused studies of patterns of care;
 1868 individual care review in specific situations; and followup
 1869 activities on previous pattern-of-care study findings and
 1870 individual-care-review findings. In designing the external
 1871 quality review function and determining how it is to operate as
 1872 part of the state's overall quality improvement system, the
 1873 agency shall construct its external quality review organization
 1874 and entity contracts to address each of the following:

1875 1. Delineating the role of the external quality review
 1876 organization.

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1877 2. Length of the external quality review organization
1878 contract with the state.

1879 3. Participation of the contracting entities in designing
1880 external quality review organization review activities.

1881 4. Potential variation in the type of clinical conditions
1882 and health services delivery issues to be studied at each plan.

1883 5. Determining the number of focused pattern-of-care
1884 studies to be conducted for each plan.

1885 6. Methods for implementing focused studies.

1886 7. Individual care review.

1887 8. Followup activities.

1888

1889 This subsection expires October 1, 2016.

1890 ~~(27)-(28)~~ In order to ensure that children receive health
1891 care services for which an entity has already been compensated,
1892 an entity contracting with the agency pursuant to this section
1893 shall achieve an annual Early and Periodic Screening, Diagnosis,
1894 and Treatment (EPSDT) Service screening rate of at least 60
1895 percent for those recipients continuously enrolled for at least
1896 8 months. The agency shall develop a method by which the EPSDT
1897 screening rate shall be calculated. For any entity which does
1898 not achieve the annual 60 percent rate, the entity must submit a
1899 corrective action plan for the agency's approval. If the entity
1900 does not meet the standard established in the corrective action
1901 plan during the specified timeframe, the agency is authorized to
1902 impose appropriate contract sanctions. At least annually, the
1903 agency shall publicly release the EPSDT Services screening rates
1904 of each entity it has contracted with on a prepaid basis to

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1905 | serve Medicaid recipients. This subsection expires October 1,
 1906 | 2014.

1907 | ~~(28)-(29)~~ The agency shall perform enrollments and
 1908 | disenrollments for Medicaid recipients who are eligible for
 1909 | MediPass or managed care plans. Notwithstanding the prohibition
 1910 | contained in paragraph ~~(20)-(21)~~(f), managed care plans may
 1911 | perform preenrollments of Medicaid recipients under the
 1912 | supervision of the agency or its agents. For the purposes of
 1913 | this section, the term "preenrollment" means the provision of
 1914 | marketing and educational materials to a Medicaid recipient and
 1915 | assistance in completing the application forms, but does not
 1916 | include actual enrollment into a managed care plan. An
 1917 | application for enrollment may not be deemed complete until the
 1918 | agency or its agent verifies that the recipient made an
 1919 | informed, voluntary choice. The agency, in cooperation with the
 1920 | Department of Children and Family Services, may test new
 1921 | marketing initiatives to inform Medicaid recipients about their
 1922 | managed care options at selected sites. The agency may contract
 1923 | with a third party to perform managed care plan and MediPass
 1924 | enrollment and disenrollment services for Medicaid recipients
 1925 | and may adopt rules to administer such services. The agency may
 1926 | adjust the capitation rate only to cover the costs of a third-
 1927 | party enrollment and disenrollment contract, and for agency
 1928 | supervision and management of the managed care plan enrollment
 1929 | and disenrollment contract. This subsection expires October 1,
 1930 | 2014.

1931 | ~~(29)-(30)~~ Any lists of providers made available to Medicaid
 1932 | recipients, MediPass enrollees, or managed care plan enrollees

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1933 shall be arranged alphabetically showing the provider's name and
 1934 specialty and, separately, by specialty in alphabetical order.

1935 This subsection expires October 1, 2014.

1936 ~~(30)~~~~(31)~~ The agency shall establish an enhanced managed
 1937 care quality assurance oversight function, to include at least
 1938 the following components:

1939 (a) At least quarterly analysis and followup, including
 1940 sanctions as appropriate, of managed care participant
 1941 utilization of services.

1942 (b) At least quarterly analysis and followup, including
 1943 sanctions as appropriate, of quality findings of the Medicaid
 1944 peer review organization and other external quality assurance
 1945 programs.

1946 (c) At least quarterly analysis and followup, including
 1947 sanctions as appropriate, of the fiscal viability of managed
 1948 care plans.

1949 (d) At least quarterly analysis and followup, including
 1950 sanctions as appropriate, of managed care participant
 1951 satisfaction and disenrollment surveys.

1952 (e) The agency shall conduct regular and ongoing Medicaid
 1953 recipient satisfaction surveys.

1954
 1955 The analyses and followup activities conducted by the agency
 1956 under its enhanced managed care quality assurance oversight
 1957 function shall not duplicate the activities of accreditation
 1958 reviewers for entities regulated under part III of chapter 641,
 1959 but may include a review of the finding of such reviewers. This
 1960 subsection expires October 1, 2014.

1961 ~~(31)~~~~(32)~~ Each managed care plan that is under contract
 1962 with the agency to provide health care services to Medicaid
 1963 recipients shall annually conduct a background check with the
 1964 Department of Law Enforcement of all persons with ownership
 1965 interest of 5 percent or more or executive management
 1966 responsibility for the managed care plan and shall submit to the
 1967 agency information concerning any such person who has been found
 1968 guilty of, regardless of adjudication, or has entered a plea of
 1969 nolo contendere or guilty to, any of the offenses listed in s.
 1970 435.04. This subsection expires October 1, 2014.

1971 ~~(32)~~~~(33)~~ The agency shall, by rule, develop a process
 1972 whereby a Medicaid managed care plan enrollee who wishes to
 1973 enter hospice care may be disenrolled from the managed care plan
 1974 within 24 hours after contacting the agency regarding such
 1975 request. The agency rule shall include a methodology for the
 1976 agency to recoup managed care plan payments on a pro rata basis
 1977 if payment has been made for the enrollment month when
 1978 disenrollment occurs. This subsection expires October 1, 2014.

1979 ~~(33)~~~~(34)~~ The agency and entities that contract with the
 1980 agency to provide health care services to Medicaid recipients
 1981 under this section or ss. 409.91211 and 409.9122 must comply
 1982 with the provisions of s. 641.513 in providing emergency
 1983 services and care to Medicaid recipients and MediPass
 1984 recipients. Where feasible, safe, and cost-effective, the agency
 1985 shall encourage hospitals, emergency medical services providers,
 1986 and other public and private health care providers to work
 1987 together in their local communities to enter into agreements or
 1988 arrangements to ensure access to alternatives to emergency

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1989 | services and care for those Medicaid recipients who need
 1990 | nonemergent care. The agency shall coordinate with hospitals,
 1991 | emergency medical services providers, private health plans,
 1992 | capitated managed care networks as established in s. 409.91211,
 1993 | and other public and private health care providers to implement
 1994 | the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405,
 1995 | and 641.31097 to develop and implement emergency department
 1996 | diversion programs for Medicaid recipients. This subsection
 1997 | expires October 1, 2014.

1998 | ~~(34)-(35)~~ All entities providing health care services to
 1999 | Medicaid recipients shall make available, and encourage all
 2000 | pregnant women and mothers with infants to receive, and provide
 2001 | documentation in the medical records to reflect, the following:

- 2002 | (a) Healthy Start prenatal or infant screening.
- 2003 | (b) Healthy Start care coordination, when screening or
 2004 | other factors indicate need.
- 2005 | (c) Healthy Start enhanced services in accordance with the
 2006 | prenatal or infant screening results.
- 2007 | (d) Immunizations in accordance with recommendations of
 2008 | the Advisory Committee on Immunization Practices of the United
 2009 | States Public Health Service and the American Academy of
 2010 | Pediatrics, as appropriate.
- 2011 | (e) Counseling and services for family planning to all
 2012 | women and their partners.
- 2013 | (f) A scheduled postpartum visit for the purpose of
 2014 | voluntary family planning, to include discussion of all methods
 2015 | of contraception, as appropriate.
- 2016 | (g) Referral to the Special Supplemental Nutrition Program

2017 | for Women, Infants, and Children (WIC).

2018

2019 | This subsection expires October 1, 2014.

2020 | (35)~~(36)~~ Any entity that provides Medicaid prepaid health
 2021 | plan services shall ensure the appropriate coordination of
 2022 | health care services with an assisted living facility in cases
 2023 | where a Medicaid recipient is both a member of the entity's
 2024 | prepaid health plan and a resident of the assisted living
 2025 | facility. If the entity is at risk for Medicaid targeted case
 2026 | management and behavioral health services, the entity shall
 2027 | inform the assisted living facility of the procedures to follow
 2028 | should an emergent condition arise. This subsection expires
 2029 | October 1, 2014.

2030 | ~~(37) The agency may seek and implement federal waivers~~
 2031 | ~~necessary to provide for cost-effective purchasing of home~~
 2032 | ~~health services, private duty nursing services, transportation,~~
 2033 | ~~independent laboratory services, and durable medical equipment~~
 2034 | ~~and supplies through competitive bidding pursuant to s. 287.057.~~
 2035 | ~~The agency may request appropriate waivers from the federal~~
 2036 | ~~Health Care Financing Administration in order to competitively~~
 2037 | ~~bid such services. The agency may exclude providers not selected~~
 2038 | ~~through the bidding process from the Medicaid provider network.~~

2039 | (36)~~(38)~~ The agency shall enter into agreements with not-
 2040 | for-profit organizations based in this state for the purpose of
 2041 | providing vision screening. This subsection expires October 1,
 2042 | 2014.

2043 | (37)~~(39)~~(a) The agency shall implement a Medicaid
 2044 | prescribed-drug spending-control program that includes the

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2045 following components:

2046 1. A Medicaid preferred drug list, which shall be a
2047 listing of cost-effective therapeutic options recommended by the
2048 Medicaid Pharmacy and Therapeutics Committee established
2049 pursuant to s. 409.91195 and adopted by the agency for each
2050 therapeutic class on the preferred drug list. At the discretion
2051 of the committee, and when feasible, the preferred drug list
2052 should include at least two products in a therapeutic class. The
2053 agency may post the preferred drug list and updates to the
2054 preferred drug list on an Internet website without following the
2055 rulemaking procedures of chapter 120. Antiretroviral agents are
2056 excluded from the preferred drug list. The agency shall also
2057 limit the amount of a prescribed drug dispensed to no more than
2058 a 34-day supply unless the drug products' smallest marketed
2059 package is greater than a 34-day supply, or the drug is
2060 determined by the agency to be a maintenance drug in which case
2061 a 100-day maximum supply may be authorized. The agency is
2062 authorized to seek any federal waivers necessary to implement
2063 these cost-control programs and to continue participation in the
2064 federal Medicaid rebate program, or alternatively to negotiate
2065 state-only manufacturer rebates. The agency may adopt rules to
2066 implement this subparagraph. The agency shall continue to
2067 provide unlimited contraceptive drugs and items. The agency must
2068 establish procedures to ensure that:

2069 a. There is a response to a request for prior consultation
2070 by telephone or other telecommunication device within 24 hours
2071 after receipt of a request for prior consultation; and

2072 b. A 72-hour supply of the drug prescribed is provided in

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2073 an emergency or when the agency does not provide a response
 2074 within 24 hours as required by sub-subparagraph a.

2075 2. Reimbursement to pharmacies for Medicaid prescribed
 2076 drugs shall be set at the lesser of: the average wholesale price
 2077 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
 2078 plus 4.75 percent, the federal upper limit (FUL), the state
 2079 maximum allowable cost (SMAC), or the usual and customary (UAC)
 2080 charge billed by the provider.

2081 3. The agency shall develop and implement a process for
 2082 managing the drug therapies of Medicaid recipients who are using
 2083 significant numbers of prescribed drugs each month. The
 2084 management process may include, but is not limited to,
 2085 comprehensive, physician-directed medical-record reviews, claims
 2086 analyses, and case evaluations to determine the medical
 2087 necessity and appropriateness of a patient's treatment plan and
 2088 drug therapies. The agency may contract with a private
 2089 organization to provide drug-program-management services. The
 2090 Medicaid drug benefit management program shall include
 2091 initiatives to manage drug therapies for HIV/AIDS patients,
 2092 patients using 20 or more unique prescriptions in a 180-day
 2093 period, and the top 1,000 patients in annual spending. The
 2094 agency shall enroll any Medicaid recipient in the drug benefit
 2095 management program if he or she meets the specifications of this
 2096 provision and is not enrolled in a Medicaid health maintenance
 2097 organization.

2098 4. The agency may limit the size of its pharmacy network
 2099 based on need, competitive bidding, price negotiations,
 2100 credentialing, or similar criteria. The agency shall give

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2101 special consideration to rural areas in determining the size and
2102 location of pharmacies included in the Medicaid pharmacy
2103 network. A pharmacy credentialing process may include criteria
2104 such as a pharmacy's full-service status, location, size,
2105 patient educational programs, patient consultation, disease
2106 management services, and other characteristics. The agency may
2107 impose a moratorium on Medicaid pharmacy enrollment when it is
2108 determined that it has a sufficient number of Medicaid-
2109 participating providers. The agency must allow dispensing
2110 practitioners to participate as a part of the Medicaid pharmacy
2111 network regardless of the practitioner's proximity to any other
2112 entity that is dispensing prescription drugs under the Medicaid
2113 program. A dispensing practitioner must meet all credentialing
2114 requirements applicable to his or her practice, as determined by
2115 the agency.

2116 5. The agency shall develop and implement a program that
2117 requires Medicaid practitioners who prescribe drugs to use a
2118 counterfeit-proof prescription pad for Medicaid prescriptions.
2119 The agency shall require the use of standardized counterfeit-
2120 proof prescription pads by Medicaid-participating prescribers or
2121 prescribers who write prescriptions for Medicaid recipients. The
2122 agency may implement the program in targeted geographic areas or
2123 statewide.

2124 6. The agency may enter into arrangements that require
2125 manufacturers of generic drugs prescribed to Medicaid recipients
2126 to provide rebates of at least 15.1 percent of the average
2127 manufacturer price for the manufacturer's generic products.
2128 These arrangements shall require that if a generic-drug

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2129 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2130 at a level below 15.1 percent, the manufacturer must provide a
2131 supplemental rebate to the state in an amount necessary to
2132 achieve a 15.1-percent rebate level.

2133 7. The agency may establish a preferred drug list as
2134 described in this subsection, and, pursuant to the establishment
2135 of such preferred drug list, it is authorized to negotiate
2136 supplemental rebates from manufacturers that are in addition to
2137 those required by Title XIX of the Social Security Act and at no
2138 less than 14 percent of the average manufacturer price as
2139 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2140 the federal or supplemental rebate, or both, equals or exceeds
2141 29 percent. There is no upper limit on the supplemental rebates
2142 the agency may negotiate. The agency may determine that specific
2143 products, brand-name or generic, are competitive at lower rebate
2144 percentages. Agreement to pay the minimum supplemental rebate
2145 percentage will guarantee a manufacturer that the Medicaid
2146 Pharmaceutical and Therapeutics Committee will consider a
2147 product for inclusion on the preferred drug list. However, a
2148 pharmaceutical manufacturer is not guaranteed placement on the
2149 preferred drug list by simply paying the minimum supplemental
2150 rebate. Agency decisions will be made on the clinical efficacy
2151 of a drug and recommendations of the Medicaid Pharmaceutical and
2152 Therapeutics Committee, as well as the price of competing
2153 products minus federal and state rebates. The agency is
2154 authorized to contract with an outside agency or contractor to
2155 conduct negotiations for supplemental rebates. For the purposes
2156 of this section, the term "supplemental rebates" means cash

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2157 rebates. Effective July 1, 2004, value-added programs as a
2158 substitution for supplemental rebates are prohibited. The agency
2159 is authorized to seek any federal waivers to implement this
2160 initiative.

2161 8. The Agency for Health Care Administration shall expand
2162 home delivery of pharmacy products. To assist Medicaid patients
2163 in securing their prescriptions and reduce program costs, the
2164 agency shall expand its current mail-order-pharmacy diabetes-
2165 supply program to include all generic and brand-name drugs used
2166 by Medicaid patients with diabetes. Medicaid recipients in the
2167 current program may obtain nondiabetes drugs on a voluntary
2168 basis. This initiative is limited to the geographic area covered
2169 by the current contract. The agency may seek and implement any
2170 federal waivers necessary to implement this subparagraph.

2171 9. The agency shall limit to one dose per month any drug
2172 prescribed to treat erectile dysfunction.

2173 10.a. The agency may implement a Medicaid behavioral drug
2174 management system. The agency may contract with a vendor that
2175 has experience in operating behavioral drug management systems
2176 to implement this program. The agency is authorized to seek
2177 federal waivers to implement this program.

2178 b. The agency, in conjunction with the Department of
2179 Children and Family Services, may implement the Medicaid
2180 behavioral drug management system that is designed to improve
2181 the quality of care and behavioral health prescribing practices
2182 based on best practice guidelines, improve patient adherence to
2183 medication plans, reduce clinical risk, and lower prescribed
2184 drug costs and the rate of inappropriate spending on Medicaid

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2185 behavioral drugs. The program may include the following
2186 elements:

2187 (I) Provide for the development and adoption of best
2188 practice guidelines for behavioral health-related drugs such as
2189 antipsychotics, antidepressants, and medications for treating
2190 bipolar disorders and other behavioral conditions; translate
2191 them into practice; review behavioral health prescribers and
2192 compare their prescribing patterns to a number of indicators
2193 that are based on national standards; and determine deviations
2194 from best practice guidelines.

2195 (II) Implement processes for providing feedback to and
2196 educating prescribers using best practice educational materials
2197 and peer-to-peer consultation.

2198 (III) Assess Medicaid beneficiaries who are outliers in
2199 their use of behavioral health drugs with regard to the numbers
2200 and types of drugs taken, drug dosages, combination drug
2201 therapies, and other indicators of improper use of behavioral
2202 health drugs.

2203 (IV) Alert prescribers to patients who fail to refill
2204 prescriptions in a timely fashion, are prescribed multiple same-
2205 class behavioral health drugs, and may have other potential
2206 medication problems.

2207 (V) Track spending trends for behavioral health drugs and
2208 deviation from best practice guidelines.

2209 (VI) Use educational and technological approaches to
2210 promote best practices, educate consumers, and train prescribers
2211 in the use of practice guidelines.

2212 (VII) Disseminate electronic and published materials.

2213 (VIII) Hold statewide and regional conferences.

2214 (IX) Implement a disease management program with a model
 2215 quality-based medication component for severely mentally ill
 2216 individuals and emotionally disturbed children who are high
 2217 users of care.

2218 11.a. The agency shall implement a Medicaid prescription
 2219 drug management system. The agency may contract with a vendor
 2220 that has experience in operating prescription drug management
 2221 systems in order to implement this system. Any management system
 2222 that is implemented in accordance with this subparagraph must
 2223 rely on cooperation between physicians and pharmacists to
 2224 determine appropriate practice patterns and clinical guidelines
 2225 to improve the prescribing, dispensing, and use of drugs in the
 2226 Medicaid program. The agency may seek federal waivers to
 2227 implement this program.

2228 b. The drug management system must be designed to improve
 2229 the quality of care and prescribing practices based on best
 2230 practice guidelines, improve patient adherence to medication
 2231 plans, reduce clinical risk, and lower prescribed drug costs and
 2232 the rate of inappropriate spending on Medicaid prescription
 2233 drugs. The program must:

2234 (I) Provide for the development and adoption of best
 2235 practice guidelines for the prescribing and use of drugs in the
 2236 Medicaid program, including translating best practice guidelines
 2237 into practice; reviewing prescriber patterns and comparing them
 2238 to indicators that are based on national standards and practice
 2239 patterns of clinical peers in their community, statewide, and
 2240 nationally; and determine deviations from best practice

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2241 guidelines.

2242 (II) Implement processes for providing feedback to and
 2243 educating prescribers using best practice educational materials
 2244 and peer-to-peer consultation.

2245 (III) Assess Medicaid recipients who are outliers in their
 2246 use of a single or multiple prescription drugs with regard to
 2247 the numbers and types of drugs taken, drug dosages, combination
 2248 drug therapies, and other indicators of improper use of
 2249 prescription drugs.

2250 (IV) Alert prescribers to patients who fail to refill
 2251 prescriptions in a timely fashion, are prescribed multiple drugs
 2252 that may be redundant or contraindicated, or may have other
 2253 potential medication problems.

2254 (V) Track spending trends for prescription drugs and
 2255 deviation from best practice guidelines.

2256 (VI) Use educational and technological approaches to
 2257 promote best practices, educate consumers, and train prescribers
 2258 in the use of practice guidelines.

2259 (VII) Disseminate electronic and published materials.

2260 (VIII) Hold statewide and regional conferences.

2261 (IX) Implement disease management programs in cooperation
 2262 with physicians and pharmacists, along with a model quality-
 2263 based medication component for individuals having chronic
 2264 medical conditions.

2265 12. The agency is authorized to contract for drug rebate
 2266 administration, including, but not limited to, calculating
 2267 rebate amounts, invoicing manufacturers, negotiating disputes
 2268 with manufacturers, and maintaining a database of rebate

2269 collections.

2270 13. The agency may specify the preferred daily dosing form
 2271 or strength for the purpose of promoting best practices with
 2272 regard to the prescribing of certain drugs as specified in the
 2273 General Appropriations Act and ensuring cost-effective
 2274 prescribing practices.

2275 14. The agency may require prior authorization for
 2276 Medicaid-covered prescribed drugs. The agency may, but is not
 2277 required to, prior-authorize the use of a product:

- 2278 a. For an indication not approved in labeling;
- 2279 b. To comply with certain clinical guidelines; or
- 2280 c. If the product has the potential for overuse, misuse,
 2281 or abuse.

2282
 2283 The agency may require the prescribing professional to provide
 2284 information about the rationale and supporting medical evidence
 2285 for the use of a drug. The agency may post prior authorization
 2286 criteria and protocol and updates to the list of drugs that are
 2287 subject to prior authorization on an Internet website without
 2288 amending its rule or engaging in additional rulemaking.

2289 15. The agency, in conjunction with the Pharmaceutical and
 2290 Therapeutics Committee, may require age-related prior
 2291 authorizations for certain prescribed drugs. The agency may
 2292 preauthorize the use of a drug for a recipient who may not meet
 2293 the age requirement or may exceed the length of therapy for use
 2294 of this product as recommended by the manufacturer and approved
 2295 by the Food and Drug Administration. Prior authorization may
 2296 require the prescribing professional to provide information

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2297 | about the rationale and supporting medical evidence for the use
2298 | of a drug.

2299 | 16. The agency shall implement a step-therapy prior
2300 | authorization approval process for medications excluded from the
2301 | preferred drug list. Medications listed on the preferred drug
2302 | list must be used within the previous 12 months prior to the
2303 | alternative medications that are not listed. The step-therapy
2304 | prior authorization may require the prescriber to use the
2305 | medications of a similar drug class or for a similar medical
2306 | indication unless contraindicated in the Food and Drug
2307 | Administration labeling. The trial period between the specified
2308 | steps may vary according to the medical indication. The step-
2309 | therapy approval process shall be developed in accordance with
2310 | the committee as stated in s. 409.91195(7) and (8). A drug
2311 | product may be approved without meeting the step-therapy prior
2312 | authorization criteria if the prescribing physician provides the
2313 | agency with additional written medical or clinical documentation
2314 | that the product is medically necessary because:

2315 | a. There is not a drug on the preferred drug list to treat
2316 | the disease or medical condition which is an acceptable clinical
2317 | alternative;

2318 | b. The alternatives have been ineffective in the treatment
2319 | of the beneficiary's disease; or

2320 | c. Based on historic evidence and known characteristics of
2321 | the patient and the drug, the drug is likely to be ineffective,
2322 | or the number of doses have been ineffective.

2323

2324 | The agency shall work with the physician to determine the best

2325 alternative for the patient. The agency may adopt rules waiving
 2326 the requirements for written clinical documentation for specific
 2327 drugs in limited clinical situations.

2328 17. The agency shall implement a return and reuse program
 2329 for drugs dispensed by pharmacies to institutional recipients,
 2330 which includes payment of a \$5 restocking fee for the
 2331 implementation and operation of the program. The return and
 2332 reuse program shall be implemented electronically and in a
 2333 manner that promotes efficiency. The program must permit a
 2334 pharmacy to exclude drugs from the program if it is not
 2335 practical or cost-effective for the drug to be included and must
 2336 provide for the return to inventory of drugs that cannot be
 2337 credited or returned in a cost-effective manner. The agency
 2338 shall determine if the program has reduced the amount of
 2339 Medicaid prescription drugs which are destroyed on an annual
 2340 basis and if there are additional ways to ensure more
 2341 prescription drugs are not destroyed which could safely be
 2342 reused. The agency's conclusion and recommendations shall be
 2343 reported to the Legislature by December 1, 2005.

2344 (b) The agency shall implement this subsection to the
 2345 extent that funds are appropriated to administer the Medicaid
 2346 prescribed-drug spending-control program. The agency may
 2347 contract all or any part of this program to private
 2348 organizations.

2349 (c) The agency shall submit quarterly reports to the
 2350 Governor, the President of the Senate, and the Speaker of the
 2351 House of Representatives which must include, but need not be
 2352 limited to, the progress made in implementing this subsection

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2353 and its effect on Medicaid prescribed-drug expenditures.

2354 (38)~~(40)~~ Notwithstanding the provisions of chapter 287,
2355 the agency may, at its discretion, renew a contract or contracts
2356 for fiscal intermediary services one or more times for such
2357 periods as the agency may decide; however, all such renewals may
2358 not combine to exceed a total period longer than the term of the
2359 original contract.

2360 (39)~~(41)~~ The agency shall provide for the development of a
2361 demonstration project by establishment in Miami-Dade County of a
2362 long-term-care facility licensed pursuant to chapter 395 to
2363 improve access to health care for a predominantly minority,
2364 medically underserved, and medically complex population and to
2365 evaluate alternatives to nursing home care and general acute
2366 care for such population. Such project is to be located in a
2367 health care condominium and colocated with licensed facilities
2368 providing a continuum of care. The establishment of this project
2369 is not subject to the provisions of s. 408.036 or s. 408.039.
2370 This subsection expires October 1, 2013.

2371 (40)~~(42)~~ The agency shall develop and implement a
2372 utilization management program for Medicaid-eligible recipients
2373 for the management of occupational, physical, respiratory, and
2374 speech therapies. The agency shall establish a utilization
2375 program that may require prior authorization in order to ensure
2376 medically necessary and cost-effective treatments. The program
2377 shall be operated in accordance with a federally approved waiver
2378 program or state plan amendment. The agency may seek a federal
2379 waiver or state plan amendment to implement this program. The
2380 agency may also competitively procure these services from an

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2381 outside vendor on a regional or statewide basis. This subsection
 2382 expires October 1, 2014.

2383 ~~(41)-(43)~~ The agency shall ~~may~~ contract on a prepaid or
 2384 fixed-sum basis with appropriately licensed prepaid dental
 2385 health plans to provide dental services. This subsection expires
 2386 October 1, 2014.

2387 ~~(42)-(44)~~ The Agency for Health Care Administration shall
 2388 ensure that any Medicaid managed care plan as defined in s.
 2389 409.9122(2)(f), whether paid on a capitated basis or a shared
 2390 savings basis, is cost-effective. For purposes of this
 2391 subsection, the term "cost-effective" means that a network's
 2392 per-member, per-month costs to the state, including, but not
 2393 limited to, fee-for-service costs, administrative costs, and
 2394 case-management fees, if any, must be no greater than the
 2395 state's costs associated with contracts for Medicaid services
 2396 established under subsection (3), which may be adjusted for
 2397 health status. The agency shall conduct actuarially sound
 2398 adjustments for health status in order to ensure such cost-
 2399 effectiveness and shall annually publish the results on its
 2400 Internet website. Contracts established pursuant to this
 2401 subsection which are not cost-effective may not be renewed. This
 2402 subsection expires October 1, 2014.

2403 ~~(43)-(45)~~ Subject to the availability of funds, the agency
 2404 shall mandate a recipient's participation in a provider lock-in
 2405 program, when appropriate, if a recipient is found by the agency
 2406 to have used Medicaid goods or services at a frequency or amount
 2407 not medically necessary, limiting the receipt of goods or
 2408 services to medically necessary providers after the 21-day

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2409 appeal process has ended, for a period of not less than 1 year.
 2410 The lock-in programs shall include, but are not limited to,
 2411 pharmacies, medical doctors, and infusion clinics. The
 2412 limitation does not apply to emergency services and care
 2413 provided to the recipient in a hospital emergency department.
 2414 The agency shall seek any federal waivers necessary to implement
 2415 this subsection. The agency shall adopt any rules necessary to
 2416 comply with or administer this subsection. This subsection
 2417 expires October 1, 2014.

2418 ~~(44)-(46)~~ The agency shall seek a federal waiver for
 2419 permission to terminate the eligibility of a Medicaid recipient
 2420 who has been found to have committed fraud, through judicial or
 2421 administrative determination, two times in a period of 5 years.

2422 ~~(47) The agency shall conduct a study of available~~
 2423 ~~electronic systems for the purpose of verifying the identity and~~
 2424 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
 2425 ~~to the Legislature a plan to implement an electronic~~
 2426 ~~verification system for Medicaid recipients by January 31, 2005.~~

2427 ~~(45)-(48)~~(a) A provider is not entitled to enrollment in
 2428 the Medicaid provider network. The agency may implement a
 2429 Medicaid fee-for-service provider network controls, including,
 2430 but not limited to, competitive procurement and provider
 2431 credentialing. If a credentialing process is used, the agency
 2432 may limit its provider network based upon the following
 2433 considerations: beneficiary access to care, provider
 2434 availability, provider quality standards and quality assurance
 2435 processes, cultural competency, demographic characteristics of
 2436 beneficiaries, practice standards, service wait times, provider

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2437 turnover, provider licensure and accreditation history, program
2438 integrity history, peer review, Medicaid policy and billing
2439 compliance records, clinical and medical record audit findings,
2440 and such other areas that are considered necessary by the agency
2441 to ensure the integrity of the program.

2442 (b) The agency shall limit its network of durable medical
2443 equipment and medical supply providers. For dates of service
2444 after January 1, 2009, the agency shall limit payment for
2445 durable medical equipment and supplies to providers that meet
2446 all the requirements of this paragraph.

2447 1. Providers must be accredited by a Centers for Medicare
2448 and Medicaid Services deemed accreditation organization for
2449 suppliers of durable medical equipment, prosthetics, orthotics,
2450 and supplies. The provider must maintain accreditation and is
2451 subject to unannounced reviews by the accrediting organization.

2452 2. Providers must provide the services or supplies
2453 directly to the Medicaid recipient or caregiver at the provider
2454 location or recipient's residence or send the supplies directly
2455 to the recipient's residence with receipt of mailed delivery.
2456 Subcontracting or consignment of the service or supply to a
2457 third party is prohibited.

2458 3. Notwithstanding subparagraph 2., a durable medical
2459 equipment provider may store nebulizers at a physician's office
2460 for the purpose of having the physician's staff issue the
2461 equipment if it meets all of the following conditions:

2462 a. The physician must document the medical necessity and
2463 need to prevent further deterioration of the patient's
2464 respiratory status by the timely delivery of the nebulizer in

2465 the physician's office.

2466 b. The durable medical equipment provider must have
 2467 written documentation of the competency and training by a
 2468 Florida-licensed registered respiratory therapist of any durable
 2469 medical equipment staff who participate in the training of
 2470 physician office staff for the use of nebulizers, including
 2471 cleaning, warranty, and special needs of patients.

2472 c. The physician's office must have documented the
 2473 training and competency of any staff member who initiates the
 2474 delivery of nebulizers to patients. The durable medical
 2475 equipment provider must maintain copies of all physician office
 2476 training.

2477 d. The physician's office must maintain inventory records
 2478 of stored nebulizers, including documentation of the durable
 2479 medical equipment provider source.

2480 e. A physician contracted with a Medicaid durable medical
 2481 equipment provider may not have a financial relationship with
 2482 that provider or receive any financial gain from the delivery of
 2483 nebulizers to patients.

2484 4. Providers must have a physical business location and a
 2485 functional landline business phone. The location must be within
 2486 the state or not more than 50 miles from the Florida state line.
 2487 The agency may make exceptions for providers of durable medical
 2488 equipment or supplies not otherwise available from other
 2489 enrolled providers located within the state.

2490 5. Physical business locations must be clearly identified
 2491 as a business that furnishes durable medical equipment or
 2492 medical supplies by signage that can be read from 20 feet away.

2493 The location must be readily accessible to the public during
 2494 normal, posted business hours and must operate at least 5 hours
 2495 per day and at least 5 days per week, with the exception of
 2496 scheduled and posted holidays. The location may not be located
 2497 within or at the same numbered street address as another
 2498 enrolled Medicaid durable medical equipment or medical supply
 2499 provider or as an enrolled Medicaid pharmacy that is also
 2500 enrolled as a durable medical equipment provider. A licensed
 2501 orthotist or prosthetist that provides only orthotic or
 2502 prosthetic devices as a Medicaid durable medical equipment
 2503 provider is exempt from this paragraph.

2504 6. Providers must maintain a stock of durable medical
 2505 equipment and medical supplies on site that is readily available
 2506 to meet the needs of the durable medical equipment business
 2507 location's customers.

2508 7. Providers must provide a surety bond of \$50,000 for
 2509 each provider location, up to a maximum of 5 bonds statewide or
 2510 an aggregate bond of \$250,000 statewide, as identified by
 2511 Federal Employer Identification Number. Providers who post a
 2512 statewide or an aggregate bond must identify all of their
 2513 locations in any Medicaid durable medical equipment and medical
 2514 supply provider enrollment application or bond renewal. Each
 2515 provider location's surety bond must be renewed annually and the
 2516 provider must submit proof of renewal even if the original bond
 2517 is a continuous bond. A licensed orthotist or prosthetist that
 2518 provides only orthotic or prosthetic devices as a Medicaid
 2519 durable medical equipment provider is exempt from the provisions
 2520 in this paragraph.

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2521 8. Providers must obtain a level 2 background screening,
2522 in accordance with chapter 435 and s. 408.809, for each provider
2523 employee in direct contact with or providing direct services to
2524 recipients of durable medical equipment and medical supplies in
2525 their homes. This requirement includes, but is not limited to,
2526 repair and service technicians, fitters, and delivery staff. The
2527 provider shall pay for the cost of the background screening.

2528 9. The following providers are exempt from subparagraphs
2529 1. and 7.:

2530 a. Durable medical equipment providers owned and operated
2531 by a government entity.

2532 b. Durable medical equipment providers that are operating
2533 within a pharmacy that is currently enrolled as a Medicaid
2534 pharmacy provider.

2535 c. Active, Medicaid-enrolled orthopedic physician groups,
2536 primarily owned by physicians, which provide only orthotic and
2537 prosthetic devices.

2538 (46)~~(49)~~ The agency shall contract with established
2539 minority physician networks that provide services to
2540 historically underserved minority patients. The networks must
2541 provide cost-effective Medicaid services, comply with the
2542 requirements to be a MediPass provider, and provide their
2543 primary care physicians with access to data and other management
2544 tools necessary to assist them in ensuring the appropriate use
2545 of services, including inpatient hospital services and
2546 pharmaceuticals.

2547 (a) The agency shall provide for the development and
2548 expansion of minority physician networks in each service area to

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2549 provide services to Medicaid recipients who are eligible to
 2550 participate under federal law and rules.

2551 (b) The agency shall reimburse each minority physician
 2552 network as a fee-for-service provider, including the case
 2553 management fee for primary care, if any, or as a capitated rate
 2554 provider for Medicaid services. Any savings shall be shared with
 2555 the minority physician networks pursuant to the contract.

2556 (c) For purposes of this subsection, the term "cost-
 2557 effective" means that a network's per-member, per-month costs to
 2558 the state, including, but not limited to, fee-for-service costs,
 2559 administrative costs, and case-management fees, if any, must be
 2560 no greater than the state's costs associated with contracts for
 2561 Medicaid services established under subsection (3), which shall
 2562 be actuarially adjusted for case mix, model, and service area.
 2563 The agency shall conduct actuarially sound audits adjusted for
 2564 case mix and model in order to ensure such cost-effectiveness
 2565 and shall annually publish the audit results on its Internet
 2566 website. Contracts established pursuant to this subsection which
 2567 are not cost-effective may not be renewed.

2568 (d) The agency may apply for any federal waivers needed to
 2569 implement this subsection.

2570
 2571 This subsection expires October 1, 2014.

2572 (47)-(50) To the extent permitted by federal law and as
 2573 allowed under s. 409.906, the agency shall provide reimbursement
 2574 for emergency mental health care services for Medicaid
 2575 recipients in crisis stabilization facilities licensed under s.
 2576 394.875 as long as those services are less expensive than the

2577 same services provided in a hospital setting.

2578 (48)~~(51)~~ The agency shall work with the Agency for Persons
 2579 with Disabilities to develop a home and community-based waiver
 2580 to serve children and adults who are diagnosed with familial
 2581 dysautonomia or Riley-Day syndrome caused by a mutation of the
 2582 IKBKAP gene on chromosome 9. The agency shall seek federal
 2583 waiver approval and implement the approved waiver subject to the
 2584 availability of funds and any limitations provided in the
 2585 General Appropriations Act. The agency may adopt rules to
 2586 implement this waiver program.

2587 (49)~~(52)~~ The agency shall implement a program of all-
 2588 inclusive care for children. The program of all-inclusive care
 2589 for children shall be established to provide in-home hospice-
 2590 like support services to children diagnosed with a life-
 2591 threatening illness and enrolled in the Children's Medical
 2592 Services network to reduce hospitalizations as appropriate. The
 2593 agency, in consultation with the Department of Health, may
 2594 implement the program of all-inclusive care for children after
 2595 obtaining approval from the Centers for Medicare and Medicaid
 2596 Services.

2597 (50)~~(53)~~ Before seeking an amendment to the state plan for
 2598 purposes of implementing programs authorized by the Deficit
 2599 Reduction Act of 2005, the agency shall notify the Legislature.

2600 Section 14. Section 409.91207, Florida Statutes, is
 2601 repealed.

2602 Section 15. Paragraphs (e), (l), (p), (w), and (dd) of
 2603 subsection (3) of section 409.91211, Florida Statutes, are
 2604 amended to read:

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2605 | 409.91211 Medicaid managed care pilot program.—

2606 | (3) The agency shall have the following powers, duties,
2607 | and responsibilities with respect to the pilot program:

2608 | (e) To implement policies and guidelines for phasing in
2609 | financial risk for approved provider service networks that, for
2610 | purposes of this paragraph, include the Children's Medical
2611 | Services Network, over the period of the waiver and the
2612 | extension thereof. These policies and guidelines must include an
2613 | option for a provider service network to be paid fee-for-service
2614 | rates. For any provider service network established in a managed
2615 | care pilot area, the option to be paid fee-for-service rates
2616 | must include a savings-settlement mechanism that is consistent
2617 | with s. 409.912 (42) ~~(44)~~. This model must be converted to a risk-
2618 | adjusted capitated rate by the beginning of the final year of
2619 | operation under the waiver extension, and may be converted
2620 | earlier at the option of the provider service network. Federally
2621 | qualified health centers may be offered an opportunity to accept
2622 | or decline a contract to participate in any provider network for
2623 | prepaid primary care services.

2624 | (1) To implement a system that prohibits capitated managed
2625 | care plans, their representatives, and providers employed by or
2626 | contracted with the capitated managed care plans from recruiting
2627 | persons eligible for or enrolled in Medicaid, from providing
2628 | inducements to Medicaid recipients to select a particular
2629 | capitated managed care plan, and from prejudicing Medicaid
2630 | recipients against other capitated managed care plans. The
2631 | system shall require the entity performing choice counseling to
2632 | determine if the recipient has made a choice of a plan or has

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2633 | opted out because of duress, threats, payment to the recipient,
 2634 | or incentives promised to the recipient by a third party. If the
 2635 | choice counseling entity determines that the decision to choose
 2636 | a plan was unlawfully influenced or a plan violated any of the
 2637 | provisions of s. 409.912(20)+~~(21)~~, the choice counseling entity
 2638 | shall immediately report the violation to the agency's program
 2639 | integrity section for investigation. Verification of choice
 2640 | counseling by the recipient shall include a stipulation that the
 2641 | recipient acknowledges the provisions of this subsection.

2642 | (p) To implement standards for plan compliance, including,
 2643 | but not limited to, standards for quality assurance and
 2644 | performance improvement, standards for peer or professional
 2645 | reviews, grievance policies, and policies for maintaining
 2646 | program integrity. The agency shall develop a data-reporting
 2647 | system, seek input from managed care plans in order to establish
 2648 | requirements for patient-encounter reporting, and ensure that
 2649 | the data reported is accurate and complete.

2650 | 1. In performing the duties required under this section,
 2651 | the agency shall work with managed care plans to establish a
 2652 | uniform system to measure and monitor outcomes for a recipient
 2653 | of Medicaid services.

2654 | 2. The system shall use financial, clinical, and other
 2655 | criteria based on pharmacy, medical services, and other data
 2656 | that is related to the provision of Medicaid services,
 2657 | including, but not limited to:

2658 | a. The Health Plan Employer Data and Information Set
 2659 | (HEDIS) or measures that are similar to HEDIS.

2660 | b. Member satisfaction.

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- 2661 c. Provider satisfaction.
- 2662 d. Report cards on plan performance and best practices.
- 2663 e. Compliance with the requirements for prompt payment of
 2664 claims under ss. 627.613, 641.3155, and 641.513.
- 2665 f. Utilization and quality data for the purpose of
 2666 ensuring access to medically necessary services, including
 2667 underutilization or inappropriate denial of services.
- 2668 3. The agency shall require the managed care plans that
 2669 have contracted with the agency to establish a quality assurance
 2670 system that incorporates the provisions of s. 409.912 (26) ~~(27)~~
 2671 and any standards, rules, and guidelines developed by the
 2672 agency.
- 2673 4. The agency shall establish an encounter database in
 2674 order to compile data on health services rendered by health care
 2675 practitioners who provide services to patients enrolled in
 2676 managed care plans in the demonstration sites. The encounter
 2677 database shall:
- 2678 a. Collect the following for each type of patient
 2679 encounter with a health care practitioner or facility,
 2680 including:
- 2681 (I) The demographic characteristics of the patient.
- 2682 (II) The principal, secondary, and tertiary diagnosis.
- 2683 (III) The procedure performed.
- 2684 (IV) The date and location where the procedure was
 2685 performed.
- 2686 (V) The payment for the procedure, if any.
- 2687 (VI) If applicable, the health care practitioner's
 2688 universal identification number.

2689 (VII) If the health care practitioner rendering the
 2690 service is a dependent practitioner, the modifiers appropriate
 2691 to indicate that the service was delivered by the dependent
 2692 practitioner.

2693 b. Collect appropriate information relating to
 2694 prescription drugs for each type of patient encounter.

2695 c. Collect appropriate information related to health care
 2696 costs and utilization from managed care plans participating in
 2697 the demonstration sites.

2698 5. To the extent practicable, when collecting the data the
 2699 agency shall use a standardized claim form or electronic
 2700 transfer system that is used by health care practitioners,
 2701 facilities, and payors.

2702 6. Health care practitioners and facilities in the
 2703 demonstration sites shall electronically submit, and managed
 2704 care plans participating in the demonstration sites shall
 2705 electronically receive, information concerning claims payments
 2706 and any other information reasonably related to the encounter
 2707 database using a standard format as required by the agency.

2708 7. The agency shall establish reasonable deadlines for
 2709 phasing in the electronic transmittal of full encounter data.

2710 8. The system must ensure that the data reported is
 2711 accurate and complete.

2712 (w) To implement procedures to minimize the risk of
 2713 Medicaid fraud and abuse in all plans operating in the Medicaid
 2714 managed care pilot program authorized in this section.

2715 1. The agency shall ensure that applicable provisions of
 2716 this chapter and chapters 414, 626, 641, and 932 which relate to

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2717 Medicaid fraud and abuse are applied and enforced at the
 2718 demonstration project sites.

2719 2. Providers must have the certification, license, and
 2720 credentials that are required by law and waiver requirements.

2721 3. The agency shall ensure that the plan is in compliance
 2722 with s. 409.912(20) and (21) and ~~(22)~~.

2723 4. The agency shall require that each plan establish
 2724 functions and activities governing program integrity in order to
 2725 reduce the incidence of fraud and abuse. Plans must report
 2726 instances of fraud and abuse pursuant to chapter 641.

2727 5. The plan shall have written administrative and
 2728 management arrangements or procedures, including a mandatory
 2729 compliance plan, which are designed to guard against fraud and
 2730 abuse. The plan shall designate a compliance officer who has
 2731 sufficient experience in health care.

2732 6.a. The agency shall require all managed care plan
 2733 contractors in the pilot program to report all instances of
 2734 suspected fraud and abuse. A failure to report instances of
 2735 suspected fraud and abuse is a violation of law and subject to
 2736 the penalties provided by law.

2737 b. An instance of fraud and abuse in the managed care
 2738 plan, including, but not limited to, defrauding the state health
 2739 care benefit program by misrepresentation of fact in reports,
 2740 claims, certifications, enrollment claims, demographic
 2741 statistics, or patient-encounter data; misrepresentation of the
 2742 qualifications of persons rendering health care and ancillary
 2743 services; bribery and false statements relating to the delivery
 2744 of health care; unfair and deceptive marketing practices; and

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2745 false claims actions in the provision of managed care, is a
 2746 violation of law and subject to the penalties provided by law.

2747 c. The agency shall require that all contractors make all
 2748 files and relevant billing and claims data accessible to state
 2749 regulators and investigators and that all such data is linked
 2750 into a unified system to ensure consistent reviews and
 2751 investigations.

2752 (dd) To implement service delivery mechanisms within a
 2753 specialty plan in area 10 to provide behavioral health care
 2754 services to Medicaid-eligible children whose cases are open for
 2755 child welfare services in the HomeSafeNet system. These services
 2756 must be coordinated with community-based care providers as
 2757 specified in s. 409.1671, where available, and be sufficient to
 2758 meet the developmental, behavioral, and emotional needs of these
 2759 children. Children in area 10 who have an open case in the
 2760 HomeSafeNet system shall be enrolled into the specialty plan.
 2761 These service delivery mechanisms must be implemented no later
 2762 than July 1, 2011, in AHCA area 10 in order for the children in
 2763 AHCA area 10 to remain exempt from the statewide plan under s.
 2764 409.912(4)(b) ~~5.8~~. An administrative fee may be paid to the
 2765 specialty plan for the coordination of services based on the
 2766 receipt of the state share of that fee being provided through
 2767 intergovernmental transfers.

2768 Section 16. Effective October 1, 2014, section 409.91211,
 2769 Florida Statutes, is repealed.

2770 Section 17. Section 409.9122, Florida Statutes, is amended
 2771 to read:

2772 409.9122 Mandatory Medicaid managed care enrollment;

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2773 | programs and procedures.—

2774 | (1) It is the intent of the Legislature that the MediPass
2775 | program be cost-effective, provide quality health care, and
2776 | improve access to health services, and that the program be
2777 | statewide. This subsection expires October 1, 2014.

2778 | (2) (a) The agency shall enroll in a managed care plan or
2779 | MediPass all Medicaid recipients, except those Medicaid
2780 | recipients who are: in an institution; enrolled in the Medicaid
2781 | medically needy program; or eligible for both Medicaid and
2782 | Medicare. Upon enrollment, individuals will be able to change
2783 | their managed care option during the 90-day opt out period
2784 | required by federal Medicaid regulations. The agency is
2785 | authorized to seek the necessary Medicaid state plan amendment
2786 | to implement this policy. However, to the extent permitted by
2787 | federal law, the agency may enroll in a managed care plan or
2788 | MediPass a Medicaid recipient who is exempt from mandatory
2789 | managed care enrollment, provided that:

2790 | 1. The recipient's decision to enroll in a managed care
2791 | plan or MediPass is voluntary;

2792 | 2. If the recipient chooses to enroll in a managed care
2793 | plan, the agency has determined that the managed care plan
2794 | provides specific programs and services which address the
2795 | special health needs of the recipient; and

2796 | 3. The agency receives any necessary waivers from the
2797 | federal Centers for Medicare and Medicaid Services.

2798 |

2799 | ~~The agency shall develop rules to establish policies by which~~
2800 | ~~exceptions to the mandatory managed care enrollment requirement~~

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2801 ~~may be made on a case-by-case basis. The rules shall include the~~
 2802 ~~specific criteria to be applied when making a determination as~~
 2803 ~~to whether to exempt a recipient from mandatory enrollment in a~~
 2804 ~~managed care plan or MediPass.~~ School districts participating in
 2805 the certified school match program pursuant to ss. 409.908(21)
 2806 and 1011.70 shall be reimbursed by Medicaid, subject to the
 2807 limitations of s. 1011.70(1), for a Medicaid-eligible child
 2808 participating in the services as authorized in s. 1011.70, as
 2809 provided for in s. 409.9071, regardless of whether the child is
 2810 enrolled in MediPass or a managed care plan. Managed care plans
 2811 shall make a good faith effort to execute agreements with school
 2812 districts regarding the coordinated provision of services
 2813 authorized under s. 1011.70. County health departments
 2814 delivering school-based services pursuant to ss. 381.0056 and
 2815 381.0057 shall be reimbursed by Medicaid for the federal share
 2816 for a Medicaid-eligible child who receives Medicaid-covered
 2817 services in a school setting, regardless of whether the child is
 2818 enrolled in MediPass or a managed care plan. Managed care plans
 2819 shall make a good faith effort to execute agreements with county
 2820 health departments regarding the coordinated provision of
 2821 services to a Medicaid-eligible child. To ensure continuity of
 2822 care for Medicaid patients, the agency, the Department of
 2823 Health, and the Department of Education shall develop procedures
 2824 for ensuring that a student's managed care plan or MediPass
 2825 provider receives information relating to services provided in
 2826 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

2827 (b) A Medicaid recipient shall not be enrolled in or
 2828 assigned to a managed care plan or MediPass unless the managed

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2829 care plan or MediPass has complied with the quality-of-care
 2830 standards specified in paragraphs (3)(a) and (b), respectively.

2831 (c) Medicaid recipients shall have a choice of managed
 2832 care plans or MediPass. The Agency for Health Care
 2833 Administration, the Department of Health, the Department of
 2834 Children and Family Services, and the Department of Elderly
 2835 Affairs shall cooperate to ensure that each Medicaid recipient
 2836 receives clear and easily understandable information that meets
 2837 the following requirements:

2838 1. Explains the concept of managed care, including
 2839 MediPass.

2840 2. Provides information on the comparative performance of
 2841 managed care plans and MediPass in the areas of quality,
 2842 credentialing, preventive health programs, network size and
 2843 availability, and patient satisfaction.

2844 3. Explains where additional information on each managed
 2845 care plan and MediPass in the recipient's area can be obtained.

2846 4. Explains that recipients have the right to choose their
 2847 managed care coverage at the time they first enroll in Medicaid
 2848 and again at regular intervals set by the agency. However, if a
 2849 recipient does not choose a managed care plan or MediPass, the
 2850 agency will assign the recipient to a managed care plan or
 2851 MediPass according to the criteria specified in this section.

2852 5. Explains the recipient's right to complain, file a
 2853 grievance, or change managed care plans or MediPass providers if
 2854 the recipient is not satisfied with the managed care plan or
 2855 MediPass.

2856 (d) The agency shall develop a mechanism for providing

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2857 information to Medicaid recipients for the purpose of making a
2858 managed care plan or MediPass selection. Examples of such
2859 mechanisms may include, but not be limited to, interactive
2860 information systems, mailings, and mass marketing materials.
2861 Managed care plans and MediPass providers are prohibited from
2862 providing inducements to Medicaid recipients to select their
2863 plans or from prejudicing Medicaid recipients against other
2864 managed care plans or MediPass providers.

2865 (e) Medicaid recipients who are already enrolled in a
2866 managed care plan or MediPass shall be offered the opportunity
2867 to change managed care plans or MediPass providers on a
2868 staggered basis, as defined by the agency. All Medicaid
2869 recipients shall have 30 days in which to make a choice of
2870 managed care plans or MediPass providers. Those Medicaid
2871 recipients who do not make a choice shall be assigned in
2872 accordance with paragraph (f). To facilitate continuity of care,
2873 for a Medicaid recipient who is also a recipient of Supplemental
2874 Security Income (SSI), prior to assigning the SSI recipient to a
2875 managed care plan or MediPass, the agency shall determine
2876 whether the SSI recipient has an ongoing relationship with a
2877 MediPass provider or managed care plan, and if so, the agency
2878 shall assign the SSI recipient to that MediPass provider or
2879 managed care plan. Those SSI recipients who do not have such a
2880 provider relationship shall be assigned to a managed care plan
2881 or MediPass provider in accordance with paragraph (f).

2882 (f) If a Medicaid recipient does not choose a managed care
2883 plan or MediPass provider, the agency shall assign the Medicaid
2884 recipient to a managed care plan or MediPass provider. Medicaid

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2885 recipients eligible for managed care plan enrollment who are
 2886 subject to mandatory assignment but who fail to make a choice
 2887 shall be assigned to managed care plans until an enrollment of
 2888 35 percent in MediPass and 65 percent in managed care plans, of
 2889 all those eligible to choose managed care, is achieved. Once
 2890 this enrollment is achieved, the assignments shall be divided in
 2891 order to maintain an enrollment in MediPass and managed care
 2892 plans which is in a 35 percent and 65 percent proportion,
 2893 respectively. Thereafter, assignment of Medicaid recipients who
 2894 fail to make a choice shall be based proportionally on the
 2895 preferences of recipients who have made a choice in the previous
 2896 period. Such proportions shall be revised at least quarterly to
 2897 reflect an update of the preferences of Medicaid recipients. The
 2898 agency shall disproportionately assign Medicaid-eligible
 2899 recipients who are required to but have failed to make a choice
 2900 of managed care plan or MediPass, ~~including children, and who~~
 2901 ~~would be assigned to the MediPass program to the children's~~
 2902 ~~networks as described in s. 409.912(4)(g),~~ Children's Medical
 2903 Services Network as defined in s. 391.021, exclusive provider
 2904 organizations, provider service networks, minority physician
 2905 networks, and pediatric emergency department diversion programs
 2906 authorized by this chapter or the General Appropriations Act, in
 2907 such manner as the agency deems appropriate, until the agency
 2908 has determined that the networks and programs have sufficient
 2909 numbers to be operated economically. For purposes of this
 2910 paragraph, when referring to assignment, the term "managed care
 2911 plans" includes health maintenance organizations, exclusive
 2912 provider organizations, provider service networks, minority

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2913 physician networks, Children's Medical Services Network, and
 2914 pediatric emergency department diversion programs authorized by
 2915 this chapter or the General Appropriations Act. When making
 2916 assignments, the agency shall take into account the following
 2917 criteria:

2918 1. A managed care plan has sufficient network capacity to
 2919 meet the need of members.

2920 2. The managed care plan or MediPass has previously
 2921 enrolled the recipient as a member, or one of the managed care
 2922 plan's primary care providers or MediPass providers has
 2923 previously provided health care to the recipient.

2924 3. The agency has knowledge that the member has previously
 2925 expressed a preference for a particular managed care plan or
 2926 MediPass provider as indicated by Medicaid fee-for-service
 2927 claims data, but has failed to make a choice.

2928 4. The managed care plan's or MediPass primary care
 2929 providers are geographically accessible to the recipient's
 2930 residence.

2931 (g) When more than one managed care plan or MediPass
 2932 provider meets the criteria specified in paragraph (f), the
 2933 agency shall make recipient assignments consecutively by family
 2934 unit.

2935 (h) The agency may not engage in practices that are
 2936 designed to favor one managed care plan over another or that are
 2937 designed to influence Medicaid recipients to enroll in MediPass
 2938 rather than in a managed care plan or to enroll in a managed
 2939 care plan rather than in MediPass. This subsection does not
 2940 prohibit the agency from reporting on the performance of

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2941 MediPass or any managed care plan, as measured by performance
2942 criteria developed by the agency.

2943 (i) After a recipient has made his or her selection or has
2944 been enrolled in a managed care plan or MediPass, the recipient
2945 shall have 90 days to exercise the opportunity to voluntarily
2946 disenroll and select another managed care plan or MediPass.
2947 After 90 days, no further changes may be made except for good
2948 cause. Good cause includes, but is not limited to, poor quality
2949 of care, lack of access to necessary specialty services, an
2950 unreasonable delay or denial of service, or fraudulent
2951 enrollment. The agency shall develop criteria for good cause
2952 disenrollment for chronically ill and disabled populations who
2953 are assigned to managed care plans if more appropriate care is
2954 available through the MediPass program. The agency must make a
2955 determination as to whether cause exists. However, the agency
2956 may require a recipient to use the managed care plan's or
2957 MediPass grievance process prior to the agency's determination
2958 of cause, except in cases in which immediate risk of permanent
2959 damage to the recipient's health is alleged. The grievance
2960 process, when utilized, must be completed in time to permit the
2961 recipient to disenroll by the first day of the second month
2962 after the month the disenrollment request was made. If the
2963 managed care plan or MediPass, as a result of the grievance
2964 process, approves an enrollee's request to disenroll, the agency
2965 is not required to make a determination in the case. The agency
2966 must make a determination and take final action on a recipient's
2967 request so that disenrollment occurs no later than the first day
2968 of the second month after the month the request was made. If the

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2969 agency fails to act within the specified timeframe, the
2970 recipient's request to disenroll is deemed to be approved as of
2971 the date agency action was required. Recipients who disagree
2972 with the agency's finding that cause does not exist for
2973 disenrollment shall be advised of their right to pursue a
2974 Medicaid fair hearing to dispute the agency's finding.

2975 (j) The agency shall apply for a federal waiver from the
2976 Centers for Medicare and Medicaid Services to lock eligible
2977 Medicaid recipients into a managed care plan or MediPass for 12
2978 months after an open enrollment period. After 12 months'
2979 enrollment, a recipient may select another managed care plan or
2980 MediPass provider. However, nothing shall prevent a Medicaid
2981 recipient from changing primary care providers within the
2982 managed care plan or MediPass program during the 12-month
2983 period.

2984 (k) When a Medicaid recipient does not choose a managed
2985 care plan or MediPass provider, the agency shall assign the
2986 Medicaid recipient to a managed care plan, except in those
2987 counties in which there are fewer than two managed care plans
2988 accepting Medicaid enrollees, in which case assignment shall be
2989 to a managed care plan or a MediPass provider. Medicaid
2990 recipients in counties with fewer than two managed care plans
2991 accepting Medicaid enrollees who are subject to mandatory
2992 assignment but who fail to make a choice shall be assigned to
2993 managed care plans until an enrollment of 35 percent in MediPass
2994 and 65 percent in managed care plans, of all those eligible to
2995 choose managed care, is achieved. Once that enrollment is
2996 achieved, the assignments shall be divided in order to maintain

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2997 an enrollment in MediPass and managed care plans which is in a
2998 35 percent and 65 percent proportion, respectively. For purposes
2999 of this paragraph, when referring to assignment, the term
3000 "managed care plans" includes exclusive provider organizations,
3001 provider service networks, Children's Medical Services Network,
3002 minority physician networks, and pediatric emergency department
3003 diversion programs authorized by this chapter or the General
3004 Appropriations Act. When making assignments, the agency shall
3005 take into account the following criteria:

3006 1. A managed care plan has sufficient network capacity to
3007 meet the need of members.

3008 2. The managed care plan or MediPass has previously
3009 enrolled the recipient as a member, or one of the managed care
3010 plan's primary care providers or MediPass providers has
3011 previously provided health care to the recipient.

3012 3. The agency has knowledge that the member has previously
3013 expressed a preference for a particular managed care plan or
3014 MediPass provider as indicated by Medicaid fee-for-service
3015 claims data, but has failed to make a choice.

3016 4. The managed care plan's or MediPass primary care
3017 providers are geographically accessible to the recipient's
3018 residence.

3019 5. The agency has authority to make mandatory assignments
3020 based on quality of service and performance of managed care
3021 plans.

3022 (1) 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

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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.

3030 (3) (a) The agency shall establish quality-of-care
 3031 standards for managed care plans. These standards shall be based
 3032 upon, but 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,
 3036 Diagnosis, 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
 3046 as 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

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3053 required of managed care plans.

3054 2. Credentialing standards for MediPass providers.

3055 3. Compliance with Early and Periodic Screening,
3056 Diagnosis, and Treatment screening requirements.

3057 4. Immunization rates.

3058 5. Specific requirements of the Medicaid program, or
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
3064 care 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
3080 Department of Elderly Affairs to assess the potential cost-

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3081 effectiveness of providing MediPass to beneficiaries who are
 3082 jointly eligible for Medicare and Medicaid on a voluntary choice
 3083 basis. If the agency determines that enrollment of these
 3084 beneficiaries in MediPass has the potential for being cost-
 3085 effective for the state, the agency shall offer MediPass to
 3086 these beneficiaries on a voluntary choice basis in the counties
 3087 where MediPass operates.

3088
 3089 This subsection expires October 1, 2014.

3090 (6) MediPass enrolled recipients may receive up to 10
 3091 visits of reimbursable services by participating Medicaid
 3092 physicians licensed under chapter 460 and up to four visits of
 3093 reimbursable services by participating Medicaid physicians
 3094 licensed under chapter 461. Any further visits must be by prior
 3095 authorization by the MediPass primary care provider. However,
 3096 nothing in this subsection may be construed to increase the
 3097 total number of visits or the total amount of dollars per year
 3098 per person under current Medicaid rules, unless otherwise
 3099 provided for in the General Appropriations Act. This subsection
 3100 expires October 1, 2014.

3101 ~~(7) The agency shall investigate the feasibility of~~
 3102 ~~developing managed care plan and MediPass options for the~~
 3103 ~~following groups of Medicaid recipients:~~

- 3104 ~~(a) Pregnant women and infants.~~
- 3105 ~~(b) Elderly and disabled recipients, especially those who~~
 3106 ~~are at risk of nursing home placement.~~
- 3107 ~~(c) Persons with developmental disabilities.~~
- 3108 ~~(d) Qualified Medicare beneficiaries.~~

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3109 ~~(e) Adults who have chronic, high-cost medical conditions.~~

3110 ~~(f) Adults and children who have mental health problems.~~

3111 ~~(g) Other recipients for whom managed care plans and~~
 3112 ~~MediPass offer the opportunity of more cost-effective care and~~
 3113 ~~greater access to qualified providers.~~

3114 ~~(8) (a) The agency shall encourage the development of~~
 3115 ~~public and private partnerships to foster the growth of health~~
 3116 ~~maintenance organizations and prepaid health plans that will~~
 3117 ~~provide high-quality health care to Medicaid recipients.~~

3118 ~~(b) Subject to the availability of moneys and any~~
 3119 ~~limitations established by the General Appropriations Act or~~
 3120 ~~chapter 216, the agency is authorized to enter into contracts~~
 3121 ~~with traditional providers of health care to low-income persons~~
 3122 ~~to assist such providers with the technical aspects of~~
 3123 ~~cooperatively developing Medicaid prepaid health plans.~~

3124 ~~1. The agency may contract with disproportionate share~~
 3125 ~~hospitals, county health departments, federally initiated or~~
 3126 ~~federally funded community health centers, and counties that~~
 3127 ~~operate either a hospital or a community clinic.~~

3128 ~~2. A contract may not be for more than \$100,000 per year,~~
 3129 ~~and no contract may be extended with any particular provider for~~
 3130 ~~more than 2 years. The contract is intended only as seed or~~
 3131 ~~development funding and requires a commitment from the~~
 3132 ~~interested party.~~

3133 ~~3. A contract must require participation by at least one~~
 3134 ~~community health clinic and one disproportionate share hospital.~~

3135 (7) ~~(9)~~ (a) The agency shall develop and implement a
 3136 comprehensive plan to ensure that recipients are adequately

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3137 informed of their choices and rights under all Medicaid managed
3138 care programs and that Medicaid managed care programs meet
3139 acceptable standards of quality in patient care, patient
3140 satisfaction, and financial solvency.

3141 (b) The agency shall provide adequate means for informing
3142 patients of their choice and rights under a managed care plan at
3143 the time of eligibility determination.

3144 (c) The agency shall require managed care plans and
3145 MediPass providers to demonstrate and document plans and
3146 activities, as defined by rule, including outreach and followup,
3147 undertaken to ensure that Medicaid recipients receive the health
3148 care service to which they are entitled.

3149

3150 This subsection expires October 1, 2014.

3151 ~~(8)-(10)~~ The agency shall consult with Medicaid consumers
3152 and their representatives on an ongoing basis regarding
3153 measurements of patient satisfaction, procedures for resolving
3154 patient grievances, standards for ensuring quality of care,
3155 mechanisms for providing patient access to services, and
3156 policies affecting patient care. This subsection expires October
3157 1, 2014.

3158 ~~(9)-(11)~~ The agency may extend eligibility for Medicaid
3159 recipients enrolled in licensed and accredited health
3160 maintenance organizations for the duration of the enrollment
3161 period or for 6 months, whichever is earlier, provided the
3162 agency certifies that such an offer will not increase state
3163 expenditures. This subsection expires October 1, 2013.

3164 ~~(10)-(12)~~ A managed care plan that has a Medicaid contract

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3165 shall at least annually review each primary care physician's
 3166 active patient load and shall ensure that additional Medicaid
 3167 recipients are not assigned to physicians who have a total
 3168 active patient load of more than 3,000 patients. As used in this
 3169 subsection, the term "active patient" means a patient who is
 3170 seen by the same primary care physician, or by a physician
 3171 assistant or advanced registered nurse practitioner under the
 3172 supervision of the primary care physician, at least three times
 3173 within a calendar year. Each primary care physician shall
 3174 annually certify to the managed care plan whether or not his or
 3175 her patient load exceeds the limits established under this
 3176 subsection and the managed care plan shall accept such
 3177 certification on face value as compliance with this subsection.
 3178 The agency shall accept the managed care plan's representations
 3179 that it is in compliance with this subsection based on the
 3180 certification of its primary care physicians, unless the agency
 3181 has an objective indication that access to primary care is being
 3182 compromised, such as receiving complaints or grievances relating
 3183 to access to care. If the agency determines that an objective
 3184 indication exists that access to primary care is being
 3185 compromised, it may verify the patient load certifications
 3186 submitted by the managed care plan's primary care physicians and
 3187 that the managed care plan is not assigning Medicaid recipients
 3188 to primary care physicians who have an active patient load of
 3189 more than 3,000 patients. This subsection expires October 1,
 3190 2014.

3191 (11)~~(13)~~ Effective July 1, 2003, the agency shall adjust
 3192 the enrollee assignment process of Medicaid managed prepaid

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3193 health plans for those Medicaid managed prepaid plans operating
 3194 in Miami-Dade County which have executed a contract with the
 3195 agency for a minimum of 8 consecutive years in order for the
 3196 Medicaid managed prepaid plan to maintain a minimum enrollment
 3197 level of 15,000 members per month. When assigning enrollees
 3198 pursuant to this subsection, the agency shall give priority to
 3199 providers that initially qualified under this subsection until
 3200 such providers reach and maintain an enrollment level of 15,000
 3201 members per month. A prepaid health plan that has a statewide
 3202 Medicaid enrollment of 25,000 or more members is not eligible
 3203 for enrollee assignments under this subsection. This subsection
 3204 expires October 1, 2014.

3205 (12) ~~(14)~~ The agency shall include in its calculation of
 3206 the hospital inpatient component of a Medicaid health
 3207 maintenance organization's capitation rate any special payments,
 3208 including, but not limited to, upper payment limit or
 3209 disproportionate share hospital payments, made to qualifying
 3210 hospitals through the fee-for-service program. The agency may
 3211 seek federal waiver approval or state plan amendment as needed
 3212 to implement this adjustment.

3213 (13) The agency shall develop a process to enable any
 3214 recipient with access to employer-sponsored health care coverage
 3215 to opt out of all eligible plans in the Medicaid program and to
 3216 use Medicaid financial assistance to pay for the recipient's
 3217 share of cost in any such employer-sponsored coverage.
 3218 Contingent on federal approval, the agency shall also enable
 3219 recipients with access to other insurance or related products
 3220 that provide access to health care services created pursuant to

3221 state law, including any plan or product available pursuant to
 3222 the Florida Health Choices Program or any health exchange, to
 3223 opt out. The amount of financial assistance provided for each
 3224 recipient may not exceed the amount of the Medicaid premium that
 3225 would have been paid to a plan for that recipient.

3226 (14) The agency shall maintain and operate the Medicaid
 3227 Encounter Data System to collect, process, store, and report on
 3228 covered services provided to all Florida Medicaid recipients
 3229 enrolled in prepaid managed care plans.

3230 (a) Prepaid managed care plans shall submit encounter data
 3231 electronically in a format that complies with the Health
 3232 Insurance Portability and Accountability Act provisions for
 3233 electronic claims and in accordance with deadlines established
 3234 by the agency. Prepaid managed care plans must certify that the
 3235 data reported is accurate and complete.

3236 (b) The agency is responsible for validating the data
 3237 submitted by the plans. The agency shall develop methods and
 3238 protocols for ongoing analysis of the encounter data that
 3239 adjusts for differences in characteristics of prepaid plan
 3240 enrollees to allow comparison of service utilization among plans
 3241 and against expected levels of use. The analysis shall be used
 3242 to identify possible cases of systemic underutilization or
 3243 denials of claims and inappropriate service utilization such as
 3244 higher-than-expected emergency department encounters. The
 3245 analysis shall provide periodic feedback to the plans and enable
 3246 the agency to establish corrective action plans when necessary.
 3247 One of the focus areas for the analysis shall be the use of
 3248 prescription drugs.

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3249 (15) The agency may establish a per-member, per-month
3250 payment for Medicare Advantage Special Needs members that are
3251 also eligible for Medicaid as a mechanism for meeting the
3252 state's cost-sharing obligation. The agency may also develop a
3253 per-member, per-month payment only for Medicaid-covered services
3254 for which the state is responsible. The agency shall develop a
3255 mechanism to ensure that such per-member, per-month payment
3256 enhances the value to the state and enrolled members by limiting
3257 cost sharing, enhances the scope of Medicare supplemental
3258 benefits that are equal to or greater than Medicaid coverage for
3259 select services, and improves care coordination.

3260 (16) The agency shall establish, and managed care plans
3261 shall use, a uniform method of accounting for and reporting
3262 medical and nonmedical costs. The agency shall make such
3263 information available to the public.

3264 (17) The agency may, on a case-by-case basis, exempt a
3265 recipient from mandatory enrollment in a managed care plan when
3266 the recipient has a unique, time-limited disease or condition-
3267 related circumstance and managed care enrollment will interfere
3268 with ongoing care because the recipient's provider does not
3269 participate in the managed care plans available in the
3270 recipient's area.

3271 (18) The agency shall contract with a single provider
3272 service network to function as a third-party administrator and
3273 managing entity for the MediPass program in all counties with
3274 fewer than two prepaid plans. The contractor may earn an
3275 administrative fee, if the fee is less than any savings
3276 determined by the reconciliation process pursuant to s.

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3277 409.912(4)(d)1. This subsection expires October 1, 2014, or upon
 3278 full implementation of the managed medical assistance program,
 3279 whichever is sooner.

3280 (19) Subject to federal approval, the agency shall
 3281 contract with a single provider service network to function as a
 3282 third-party administrator and managing entity for the Medically
 3283 Needy program in all counties. The contractor shall provide care
 3284 coordination and utilization management in order to achieve more
 3285 cost-effective services for Medically Needy enrollees. To
 3286 facilitate the care management functions of the provider service
 3287 network, enrollment in the network shall be for a continuous 6-
 3288 month period or until the end of the contract between the
 3289 provider service network and the agency, whichever is sooner.
 3290 Beginning the second month after the determination of
 3291 eligibility, the contractor may collect a monthly premium from
 3292 each Medically Needy recipient provided the premium does not
 3293 exceed the enrollee's share of cost as determined by the
 3294 Department of Children and Family Services. The contractor must
 3295 provide a 90-day grace period before disenrolling a Medically
 3296 Needy recipient for failure to pay premiums. The contractor may
 3297 earn an administrative fee, if the fee is less than any savings
 3298 determined by the reconciliation process pursuant to s.
 3299 409.912(4)(d)1. Premium revenue collected from the recipients
 3300 shall be deducted from the contractor's earned savings. This
 3301 subsection expires October 1, 2014, or upon full implementation
 3302 of the managed medical assistance program, whichever is sooner.

3303 Section 18. Subsection (15) of section 430.04, Florida
 3304 Statutes, is amended to read:

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3305 430.04 Duties and responsibilities of the Department of
 3306 Elderly Affairs.—The Department of Elderly Affairs shall:

3307 (15) Administer all Medicaid waivers and programs relating
 3308 to elders and their appropriations. The waivers include, but are
 3309 not limited to:

3310 ~~(a) The Alzheimer's Dementia Specific Medicaid Waiver as~~
 3311 ~~established in s. 430.502(7), (8), and (9).~~

3312 (a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.

3313 (b) ~~(e)~~ The Aged and Disabled Adult Waiver.

3314 (c) ~~(d)~~ The Adult Day Health Care Waiver.

3315 (d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined
 3316 in s. 409.221.

3317 (e) ~~(f)~~ The Program of All-inclusive Care for the Elderly.

3318 (f) ~~(g)~~ The Long-Term Care Community-Based Diversion Pilot
 3319 Project as described in s. 430.705.

3320 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.

3321
 3322 The department shall develop a transition plan for recipients
 3323 receiving services in long-term care Medicaid waivers for elders
 3324 or disabled adults on the date eligible plans become available
 3325 in each recipient's region defined in s. 409.981(2) to enroll
 3326 those recipients in eligible plans. This subsection expires
 3327 October 1, 2014.

3328 Section 19. Section 430.2053, Florida Statutes, is amended
 3329 to read:

3330 430.2053 Aging resource centers.—

3331 (1) The department, in consultation with the Agency for
 3332 Health Care Administration and the Department of Children and

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3333 Family Services, shall develop pilot projects for aging resource
3334 centers. ~~By October 31, 2004, the department, in consultation~~
3335 ~~with the agency and the Department of Children and Family~~
3336 ~~Services, shall develop an implementation plan for aging~~
3337 ~~resource centers and submit the plan to the Governor, the~~
3338 ~~President of the Senate, and the Speaker of the House of~~
3339 ~~Representatives. The plan must include qualifications for~~
3340 ~~designation as a center, the functions to be performed by each~~
3341 ~~center, and a process for determining that a current area agency~~
3342 ~~on aging is ready to assume the functions of an aging resource~~
3343 ~~center.~~

3344 ~~(2) Each area agency on aging shall develop, in~~
3345 ~~consultation with the existing community care for the elderly~~
3346 ~~lead agencies within their planning and service areas, a~~
3347 ~~proposal that describes the process the area agency on aging~~
3348 ~~intends to undertake to transition to an aging resource center~~
3349 ~~prior to July 1, 2005, and that describes the area agency's~~
3350 ~~compliance with the requirements of this section. The proposals~~
3351 ~~must be submitted to the department prior to December 31, 2004.~~
3352 ~~The department shall evaluate all proposals for readiness and,~~
3353 ~~prior to March 1, 2005, shall select three area agencies on~~
3354 ~~aging which meet the requirements of this section to begin the~~
3355 ~~transition to aging resource centers. Those area agencies on~~
3356 ~~aging which are not selected to begin the transition to aging~~
3357 ~~resource centers shall, in consultation with the department and~~
3358 ~~the existing community care for the elderly lead agencies within~~
3359 ~~their planning and service areas, amend their proposals as~~
3360 ~~necessary and resubmit them to the department prior to July 1,~~

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3361 ~~2005. The department may transition additional area agencies to~~
 3362 ~~aging resource centers as it determines that area agencies are~~
 3363 ~~in compliance with the requirements of this section.~~

3364 ~~(3) The Auditor General and the Office of Program Policy~~
 3365 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
 3366 ~~review and assess the department's process for determining an~~
 3367 ~~area agency's readiness to transition to an aging resource~~
 3368 ~~center.~~

3369 ~~(a) The review must, at a minimum, address the~~
 3370 ~~appropriateness of the department's criteria for selection of an~~
 3371 ~~area agency to transition to an aging resource center, the~~
 3372 ~~instruments applied, the degree to which the department~~
 3373 ~~accurately determined each area agency's compliance with the~~
 3374 ~~readiness criteria, the quality of the technical assistance~~
 3375 ~~provided by the department to an area agency in correcting any~~
 3376 ~~weaknesses identified in the readiness assessment, and the~~
 3377 ~~degree to which each area agency overcame any identified~~
 3378 ~~weaknesses.~~

3379 ~~(b) Reports of these reviews must be submitted to the~~
 3380 ~~appropriate substantive and appropriations committees in the~~
 3381 ~~Senate and the House of Representatives on March 1 and September~~
 3382 ~~1 of each year until full transition to aging resource centers~~
 3383 ~~has been accomplished statewide, except that the first report~~
 3384 ~~must be submitted by February 1, 2005, and must address all~~
 3385 ~~readiness activities undertaken through December 31, 2004. The~~
 3386 ~~perspectives of all participants in this review process must be~~
 3387 ~~included in each report.~~

3388 (2)~~(4)~~ The purposes of an aging resource center shall be:

3389 (a) To provide Florida's elders and their families with a
 3390 locally focused, coordinated approach to integrating information
 3391 and referral for all available services for elders with the
 3392 eligibility determination entities for state and federally
 3393 funded long-term-care services.

3394 (b) To provide for easier access to long-term-care
 3395 services by Florida's elders and their families by creating
 3396 multiple access points to the long-term-care network that flow
 3397 through one established entity with wide community recognition.

3398 (3)~~(5)~~ The duties of an aging resource center are to:

3399 (a) Develop referral agreements with local community
 3400 service organizations, such as senior centers, existing elder
 3401 service providers, volunteer associations, and other similar
 3402 organizations, to better assist clients who do not need or do
 3403 not wish to enroll in programs funded by the department or the
 3404 agency. The referral agreements must also include a protocol,
 3405 developed and approved by the department, which provides
 3406 specific actions that an aging resource center and local
 3407 community service organizations must take when an elder or an
 3408 elder's representative seeking information on long-term-care
 3409 services contacts a local community service organization prior
 3410 to contacting the aging resource center. The protocol shall be
 3411 designed to ensure that elders and their families are able to
 3412 access information and services in the most efficient and least
 3413 cumbersome manner possible.

3414 (b) Provide an initial screening of all clients who
 3415 request long-term-care services to determine whether the person
 3416 would be most appropriately served through any combination of

3417 federally funded programs, state-funded programs, locally funded
 3418 or community volunteer programs, or private funding for
 3419 services.

3420 (c) Determine eligibility for the programs and services
 3421 listed in subsection (9) ~~(11)~~ for persons residing within the
 3422 geographic area served by the aging resource center and
 3423 determine a priority ranking for services which is based upon
 3424 the potential recipient's frailty level and likelihood of
 3425 institutional placement without such services.

3426 (d) Manage the availability of financial resources for the
 3427 programs and services listed in subsection (9) ~~(11)~~ for persons
 3428 residing within the geographic area served by the aging resource
 3429 center.

3430 (e) When financial resources become available, refer a
 3431 client to the most appropriate entity to begin receiving
 3432 services. The aging resource center shall make referrals to lead
 3433 agencies for service provision that ensure that individuals who
 3434 are vulnerable adults in need of services pursuant to s.
 3435 415.104(3)(b), or who are victims of abuse, neglect, or
 3436 exploitation in need of immediate services to prevent further
 3437 harm and are referred by the adult protective services program,
 3438 are given primary consideration for receiving community-care-
 3439 for-the-elderly services in compliance with the requirements of
 3440 s. 430.205(5)(a) and that other referrals for services are in
 3441 compliance with s. 430.205(5)(b).

3442 (f) Convene a work group to advise in the planning,
 3443 implementation, and evaluation of the aging resource center. The
 3444 work group shall be comprised of representatives of local

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3445 service providers, Alzheimer's Association chapters, housing
 3446 authorities, social service organizations, advocacy groups,
 3447 representatives of clients receiving services through the aging
 3448 resource center, and any other persons or groups as determined
 3449 by the department. The aging resource center, in consultation
 3450 with the work group, must develop annual program improvement
 3451 plans that shall be submitted to the department for
 3452 consideration. The department shall review each annual
 3453 improvement plan and make recommendations on how to implement
 3454 the components of the plan.

3455 (g) Enhance the existing area agency on aging in each
 3456 planning and service area by integrating, either physically or
 3457 virtually, the staff and services of the area agency on aging
 3458 with the staff of the department's local CARES Medicaid ~~nursing~~
 3459 ~~home~~ preadmission screening unit and a sufficient number of
 3460 staff from the Department of Children and Family Services'
 3461 Economic Self-Sufficiency Unit necessary to determine the
 3462 financial eligibility for all persons age 60 and older residing
 3463 within the area served by the aging resource center that are
 3464 seeking Medicaid services, Supplemental Security Income, and
 3465 food assistance.

3466 (h) Assist clients who request long-term care services in
 3467 being evaluated for eligibility for enrollment in the Medicaid
 3468 long-term care managed care program as eligible plans become
 3469 available in each of the regions pursuant to s. 409.981(2).

3470 (i) Provide choice counseling for the Medicaid long-term
 3471 care managed care program by integrating, either physically or
 3472 virtually, choice counseling staff and services as eligible

3473 plans become available in each of the regions pursuant to s.
 3474 409.981(2). Pursuant to s. 409.984(1), the agency may contract
 3475 directly with the aging resource center to provide choice
 3476 counseling services or may contract with another vendor if the
 3477 aging resource center does not choose to provide such services.

3478 (j) Assist Medicaid recipients enrolled in the Medicaid
 3479 long-term care managed care program with informally resolving
 3480 grievances with a managed care network and assist Medicaid
 3481 recipients in accessing the managed care network's formal
 3482 grievance process as eligible plans become available in each of
 3483 the regions defined in s. 409.981(2).

3484 (4)~~(6)~~ The department shall select the entities to become
 3485 aging resource centers based on each entity's readiness and
 3486 ability to perform the duties listed in subsection (3) ~~(5)~~ and
 3487 the entity's:

3488 (a) Expertise in the needs of each target population the
 3489 center proposes to serve and a thorough knowledge of the
 3490 providers that serve these populations.

3491 (b) Strong connections to service providers, volunteer
 3492 agencies, and community institutions.

3493 (c) Expertise in information and referral activities.

3494 (d) Knowledge of long-term-care resources, including
 3495 resources designed to provide services in the least restrictive
 3496 setting.

3497 (e) Financial solvency and stability.

3498 (f) Ability to collect, monitor, and analyze data in a
 3499 timely and accurate manner, along with systems that meet the
 3500 department's standards.

3501 (g) Commitment to adequate staffing by qualified personnel
 3502 to effectively perform all functions.

3503 (h) Ability to meet all performance standards established
 3504 by the department.

3505 (5)~~(7)~~ The aging resource center shall have a governing
 3506 body which shall be the same entity described in s. 20.41(7),
 3507 and an executive director who may be the same person as
 3508 described in s. 20.41(7). The governing body shall annually
 3509 evaluate the performance of the executive director.

3510 (6)~~(8)~~ The aging resource center may not be a provider of
 3511 direct services other than choice counseling as eligible plans
 3512 become available in each of the regions defined in s.
 3513 409.981(2), information and referral services, and screening.

3514 (7)~~(9)~~ The aging resource center must agree to allow the
 3515 department to review any financial information the department
 3516 determines is necessary for monitoring or reporting purposes,
 3517 including financial relationships.

3518 (8)~~(10)~~ The duties and responsibilities of the community
 3519 care for the elderly lead agencies within each area served by an
 3520 aging resource center shall be to:

3521 (a) Develop strong community partnerships to maximize the
 3522 use of community resources for the purpose of assisting elders
 3523 to remain in their community settings for as long as it is
 3524 safely possible.

3525 (b) Conduct comprehensive assessments of clients that have
 3526 been determined eligible and develop a care plan consistent with
 3527 established protocols that ensures that the unique needs of each
 3528 client are met.

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3529 (9)~~(11)~~ The services to be administered through the aging
 3530 resource center shall include those funded by the following
 3531 programs:

- 3532 (a) Community care for the elderly.
- 3533 (b) Home care for the elderly.
- 3534 (c) Contracted services.
- 3535 (d) Alzheimer's disease initiative.
- 3536 (e) Aged and disabled adult Medicaid waiver. This
 3537 paragraph expires October 1, 2013.
- 3538 (f) Assisted living for the frail elderly Medicaid waiver.
 3539 This paragraph expires October 1, 2013.
- 3540 (g) Older Americans Act.

3541 (10)~~(12)~~ The department shall, prior to designation of an
 3542 aging resource center, develop by rule operational and quality
 3543 assurance standards and outcome measures to ensure that clients
 3544 receiving services through all long-term-care programs
 3545 administered through an aging resource center are receiving the
 3546 appropriate care they require and that contractors and
 3547 subcontractors are adhering to the terms of their contracts and
 3548 are acting in the best interests of the clients they are
 3549 serving, consistent with the intent of the Legislature to reduce
 3550 the use of and cost of nursing home care. The department shall
 3551 by rule provide operating procedures for aging resource centers,
 3552 which shall include:

- 3553 (a) Minimum standards for financial operation, including
 3554 audit procedures.
- 3555 (b) Procedures for monitoring and sanctioning of service
 3556 providers.

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3557 (c) Minimum standards for technology utilized by the aging
3558 resource center.

3559 (d) Minimum staff requirements which shall ensure that the
3560 aging resource center employs sufficient quality and quantity of
3561 staff to adequately meet the needs of the elders residing within
3562 the area served by the aging resource center.

3563 (e) Minimum accessibility standards, including hours of
3564 operation.

3565 (f) Minimum oversight standards for the governing body of
3566 the aging resource center to ensure its continuous involvement
3567 in, and accountability for, all matters related to the
3568 development, implementation, staffing, administration, and
3569 operations of the aging resource center.

3570 (g) Minimum education and experience requirements for
3571 executive directors and other executive staff positions of aging
3572 resource centers.

3573 (h) Minimum requirements regarding any executive staff
3574 positions that the aging resource center must employ and minimum
3575 requirements that a candidate must meet in order to be eligible
3576 for appointment to such positions.

3577 (11) ~~(13)~~ In an area in which the department has designated
3578 an area agency on aging as an aging resource center, the
3579 department and the agency shall not make payments for the
3580 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
3581 Community Diversion Project for such persons who were not
3582 screened and enrolled through the aging resource center. The
3583 department shall cease making payments for recipients in
3584 eligible plans as eligible plans become available in each of the

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3585 regions defined in s. 409.981(2).

3586 ~~(12)-(14)~~ Each aging resource center shall enter into a
3587 memorandum of understanding with the department for
3588 collaboration with the CARES unit staff. The memorandum of
3589 understanding shall outline the staff person responsible for
3590 each function and shall provide the staffing levels necessary to
3591 carry out the functions of the aging resource center.

3592 ~~(13)-(15)~~ Each aging resource center shall enter into a
3593 memorandum of understanding with the Department of Children and
3594 Family Services for collaboration with the Economic Self-
3595 Sufficiency Unit staff. The memorandum of understanding shall
3596 outline which staff persons are responsible for which functions
3597 and shall provide the staffing levels necessary to carry out the
3598 functions of the aging resource center.

3599 (14) As eligible plans become available in each of the
3600 regions defined in s. 409.981(2), if an aging resource center
3601 does not contract with the agency to provide Medicaid long-term
3602 care managed care choice counseling pursuant to s. 409.984(1),
3603 the aging resource center shall enter into a memorandum of
3604 understanding with the agency to coordinate staffing and
3605 collaborate with the choice counseling vendor. The memorandum of
3606 understanding shall identify the staff responsible for each
3607 function and shall provide the staffing levels necessary to
3608 carry out the functions of the aging resource center.

3609 ~~(15)-(16)~~ If any of the state activities described in this
3610 section are outsourced, either in part or in whole, the contract
3611 executing the outsourcing shall mandate that the contractor or
3612 its subcontractors shall, either physically or virtually,

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3613 execute the provisions of the memorandum of understanding
 3614 instead of the state entity whose function the contractor or
 3615 subcontractor now performs.

3616 (16)~~(17)~~ In order to be eligible to begin transitioning to
 3617 an aging resource center, an area agency on aging board must
 3618 ensure that the area agency on aging which it oversees meets all
 3619 of the minimum requirements set by law and in rule.

3620 ~~(18) The department shall monitor the three initial~~
 3621 ~~projects for aging resource centers and report on the progress~~
 3622 ~~of those projects to the Governor, the President of the Senate,~~
 3623 ~~and the Speaker of the House of Representatives by June 30,~~
 3624 ~~2005. The report must include an evaluation of the~~
 3625 ~~implementation process.~~

3626 (17)~~(19)~~ (a) Once an aging resource center is operational,
 3627 the department, in consultation with the agency, may develop
 3628 capitation rates for any of the programs administered through
 3629 the aging resource center. Capitation rates for programs shall
 3630 be based on the historical cost experience of the state in
 3631 providing those same services to the population age 60 or older
 3632 residing within each area served by an aging resource center.
 3633 Each capitated rate may vary by geographic area as determined by
 3634 the department.

3635 (b) The department and the agency may determine for each
 3636 area served by an aging resource center whether it is
 3637 appropriate, consistent with federal and state laws and
 3638 regulations, to develop and pay separate capitated rates for
 3639 each program administered through the aging resource center or
 3640 to develop and pay capitated rates for service packages which

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3641 include more than one program or service administered through
 3642 the aging resource center.

3643 (c) Once capitation rates have been developed and
 3644 certified as actuarially sound, the department and the agency
 3645 may pay service providers the capitated rates for services when
 3646 appropriate.

3647 (d) The department, in consultation with the agency, shall
 3648 annually reevaluate and recertify the capitation rates,
 3649 adjusting forward to account for inflation, programmatic
 3650 changes.

3651 ~~(20) The department, in consultation with the agency,~~
 3652 ~~shall submit to the Governor, the President of the Senate, and~~
 3653 ~~the Speaker of the House of Representatives, by December 1,~~
 3654 ~~2006, a report addressing the feasibility of administering the~~
 3655 ~~following services through aging resource centers beginning July~~
 3656 ~~1, 2007:~~

- 3657 ~~(a) Medicaid nursing home services.~~
- 3658 ~~(b) Medicaid transportation services.~~
- 3659 ~~(c) Medicaid hospice care services.~~
- 3660 ~~(d) Medicaid intermediate care services.~~
- 3661 ~~(e) Medicaid prescribed drug services.~~
- 3662 ~~(f) Medicaid assistive care services.~~
- 3663 ~~(g) Any other long term care program or Medicaid service.~~

3664 (18) ~~(21)~~ This section shall not be construed to allow an
 3665 aging resource center to restrict, manage, or impede the local
 3666 fundraising activities of service providers.

3667 Section 20. Effective October 1, 2013, sections 430.701,
 3668 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707,
 3669 430.708, and 430.709, Florida Statutes, are repealed.

3670 Section 21. Sections 409.9301, 409.942, 409.944, 409.945,
 3671 409.946, 409.953, and 409.9531, Florida Statutes, are renumbered
 3672 as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
 3673 402.87, Florida Statutes, respectively.

3674 Section 22. Paragraph (a) of subsection (1) of section
 3675 443.111, Florida Statutes, is amended to read:

3676 443.111 Payment of benefits.—

3677 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
 3678 in accordance with rules adopted by the Agency for Workforce
 3679 Innovation, subject to the following requirements:

3680 (a) Benefits are payable by mail or electronically.
 3681 Notwithstanding s. 402.84(4) ~~s. 409.942(4)~~, the agency may
 3682 develop a system for the payment of benefits by electronic funds
 3683 transfer, including, but not limited to, debit cards, electronic
 3684 payment cards, or any other means of electronic payment that the
 3685 agency deems to be commercially viable or cost-effective.
 3686 Commodities or services related to the development of such a
 3687 system shall be procured by competitive solicitation, unless
 3688 they are purchased from a state term contract pursuant to s.
 3689 287.056. The agency shall adopt rules necessary to administer
 3690 the system.

3691 Section 23. Subsection (4) of section 641.386, Florida
 3692 Statutes, is amended to read:

3693 641.386 Agent licensing and appointment required;
 3694 exceptions.—

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3695 (4) All agents and health maintenance organizations shall
 3696 comply with and be subject to the applicable provisions of ss.
 3697 641.309 and 409.912 (20) ~~(21)~~, and all companies and entities
 3698 appointing agents shall comply with s. 626.451, when marketing
 3699 for any health maintenance organization licensed pursuant to
 3700 this part, including those organizations under contract with the
 3701 Agency for Health Care Administration to provide health care
 3702 services to Medicaid recipients or any private entity providing
 3703 health care services to Medicaid recipients pursuant to a
 3704 prepaid health plan contract with the Agency for Health Care
 3705 Administration.

3706 Section 24. Subsections (6) and (7) of section 766.118,
 3707 Florida Statutes, are renumbered as subsections (7) and (8),
 3708 respectively, and a new subsection (6) is added to that section,
 3709 to read:

3710 766.118 Determination of noneconomic damages.—

3711 (6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF
 3712 PRACTITIONERS PROVIDING SERVICES AND CARE TO MEDICAID
 3713 RECIPIENTS.—Notwithstanding subsections (2), (3), (4), and (5),
 3714 with respect to a cause of action for personal injury or
 3715 wrongful death arising from medical negligence of practitioners
 3716 providing services and care to Medicaid recipients as defined in
 3717 s. 409.901, regardless of the number of such practitioner
 3718 defendants providing services and care to Medicaid recipients as
 3719 defined in s. 409.901, noneconomic damages may not exceed
 3720 \$300,000 per claimant. A practitioner providing services and
 3721 care to Medicaid recipients as defined in s. 409.901 is not

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3722 liable for more than \$200,000 in noneconomic damages, regardless
3723 of the number of claimants.

3724 Section 25. The Agency for Health Care Administration
3725 shall develop a plan for implementing s. 409.975(8), Florida
3726 Statutes, and shall immediately seek federal approval to
3727 implement that subsection. The plan shall include a preliminary
3728 calculation of actuarially sound rates and estimated fiscal
3729 impact.

3730 Section 26. Except as otherwise expressly provided in this
3731 act, this act shall take effect July 1, 2011, if HB 7107 or
3732 similar legislation is adopted in the same legislative session
3733 or an extension thereof and becomes law.