

By Senator Simmons

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1                   A reviser's bill to be entitled  
2           An act relating to the Florida Statutes; repealing ss.  
3           88.7011, 120.745, 163.336, 218.077(5), 220.33(7),  
4           253.01(2)(b), 288.106(4)(f), 339.08(1)(n), 381.0407,  
5           403.709(1)(f), 409.911(10), 409.91211, 430.04(15),  
6           430.502(10)-(12), 443.131(5), 624.351, 624.352, and  
7           626.2815(7), F.S., and amending ss. 110.123, 339.135,  
8           409.912, 409.9122, 576.061, 828.27, and 1002.32, F.S.,  
9           to delete provisions which have become inoperative by  
10          noncurrent repeal or expiration and, pursuant to s.  
11          11.242(5)(b) and (i), F.S., may be omitted from the  
12          2015 Florida Statutes only through a reviser's bill  
13          duly enacted by the Legislature; amending ss.  
14          409.91195, 409.91196, 409.962, 636.0145, 641.19,  
15          641.225, and 641.386, F.S., to conform cross-  
16          references; providing an effective date.

17  
18 Be It Enacted by the Legislature of the State of Florida:

19  
20           Section 1. Section 88.7011, Florida Statutes, is repealed.  
21 Reviser's note.—Repealed to conform to s. 58, ch. 2011-92, Laws  
22 of Florida, which repealed s. 88.7011 effective on a date  
23 contingent upon the provisions of s. 81, ch. 2011-92.  
24 Section 81, ch. 2011-92, provides that "[e]xcept as  
25 otherwise expressly provided in this act, this act shall  
26 take effect upon the earlier of 90 days following Congress  
27 amending 42 U.S.C. s. 666(f) to allow or require states to  
28 adopt the 2008 version of the Uniform Interstate Family  
29 Support Act, or 90 days following the state obtaining a

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30 waiver of its state plan requirement under Title IV-D of  
31 the Social Security Act." Public Law No. 113-183 was signed  
32 by the President on September 29, 2014; a portion of that  
33 law requires that the 2008 version of the Uniform  
34 Interstate Family Support Act is required.

35 Section 2. Paragraph (g) of subsection (3) of section  
36 110.123, Florida Statutes, is amended to read:

37 110.123 State group insurance program.—

38 (3) STATE GROUP INSURANCE PROGRAM.—

39 (g) Participation by individuals in the program is  
40 available to all state officers, full-time state employees, and  
41 part-time state employees and is voluntary. Participation in the  
42 program is also available to retired state officers and  
43 employees who elect at the time of retirement to continue  
44 coverage under the program, but may elect to continue all or  
45 only part of the coverage they had at the time of retirement. A  
46 surviving spouse may elect to continue coverage only under a  
47 state group health insurance plan, a TRICARE supplemental  
48 insurance plan, or a health maintenance organization plan.

49 ~~1. Full-time state employees described in subparagraph~~  
50 ~~(2)(c)1. are eligible for health insurance coverage in calendar~~  
51 ~~year 2014 as long as they remain employed by an employer~~  
52 ~~participating in the state group insurance program during the~~  
53 ~~year. This subparagraph expires December 31, 2014.~~

54 ~~2. Employees paid from other personal services (OPS) funds~~  
55 ~~are not eligible for coverage before January 1, 2014.~~

56 Reviser's note.—Amended to delete subparagraph (3)(g)1., which  
57 expired pursuant to its own terms, effective December 31,  
58 2014, and to delete subparagraph (3)(g)2. to repeal a

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59 provision that has served its purpose.

60 Section 3. Section 120.745, Florida Statutes, is repealed.

61 Reviser's note.—The cited section, which relates to legislative  
62 review of agency rules in effect on or before November 16,  
63 2010, was repealed pursuant to its own terms, effective  
64 July 1, 2014.

65 Section 4. Section 163.336, Florida Statutes, is repealed.

66 Reviser's note.—The cited section, which relates to the coastal  
67 resort area redevelopment pilot project, expired pursuant  
68 to its own terms, effective December 31, 2014.

69 Section 5. Subsection (5) of section 218.077, Florida  
70 Statutes, is repealed.

71 Reviser's note.—The cited subsection, which relates to the  
72 Employer-Sponsored Benefits Study Task Force, was repealed  
73 pursuant to its own terms, effective June 30, 2014.

74 Section 6. Subsection (7) of section 220.33, Florida  
75 Statutes, is repealed.

76 Reviser's note.—The cited subsection, which relates to payment  
77 of estimated tax due no later than Sunday, June 30, 2013,  
78 by June 28, 2013, expired pursuant to its own terms,  
79 effective July 1, 2014.

80 Section 7. Paragraph (b) of subsection (2) of section  
81 253.01, Florida Statutes, is repealed.

82 Reviser's note.—The cited paragraph, which relates to transfer  
83 of moneys, for the 2013-2014 fiscal year only, from the  
84 Internal Improvement Trust Fund to the Save Our Everglades  
85 Trust Fund for Everglades restoration pursuant to s.  
86 216.181(12), expired pursuant to its own terms, effective  
87 July 1, 2014.

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88           Section 8. Paragraph (f) of subsection (4) of section  
89 288.106, Florida Statutes, is repealed.

90 Reviser's note.—The cited paragraph, which permits reduction of  
91 local financial support requirements of s. 288.106 by one-  
92 half for a qualified target industry business located in  
93 one of a specified list of counties under certain  
94 circumstances, expired pursuant to its own terms, effective  
95 June 30, 2014.

96           Section 9. Paragraph (n) of subsection (1) of section  
97 339.08, Florida Statutes, is repealed.

98 Reviser's note.—The cited paragraph, which relates to  
99 expenditure of funds to pay administrative expenses  
100 incurred in accordance with applicable laws by the  
101 multicounty transportation authority created under chapter  
102 343 where jurisdiction for the authority includes a portion  
103 of the State Highway System and the expenses are in  
104 furtherance of the provisions of chapter 2012-174, Laws of  
105 Florida, to provide a financial analysis of the cost  
106 savings to be achieved by the consolidation of transit  
107 authorities within the region, expired pursuant to its own  
108 terms, effective July 1, 2014.

109           Section 10. Paragraph (a) of subsection (4) of section  
110 339.135, Florida Statutes, is amended to read:

111           339.135 Work program; legislative budget request;  
112 definitions; preparation, adoption, execution, and amendment.—

113           (4) FUNDING AND DEVELOPING A TENTATIVE WORK PROGRAM.—

114           (a)1. To assure that no district or county is penalized for  
115 local efforts to improve the State Highway System, the  
116 department shall, for the purpose of developing a tentative work

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117 program, allocate funds for new construction to the districts,  
118 except for the turnpike enterprise, based on equal parts of  
119 population and motor fuel tax collections. Funds for  
120 resurfacing, bridge repair and rehabilitation, bridge fender  
121 system construction or repair, public transit projects except  
122 public transit block grants as provided in s. 341.052, and other  
123 programs with quantitative needs assessments shall be allocated  
124 based on the results of these assessments. The department may  
125 not transfer any funds allocated to a district under this  
126 paragraph to any other district except as provided in subsection  
127 (7). Funds for public transit block grants shall be allocated to  
128 the districts pursuant to s. 341.052. Funds for the intercity  
129 bus program provided for under s. 5311(f) of the federal  
130 nonurbanized area formula program shall be administered and  
131 allocated directly to eligible bus carriers as defined in s.  
132 341.031(12) at the state level rather than the district. In  
133 order to provide state funding to support the intercity bus  
134 program provided for under provisions of the federal 5311(f)  
135 program, the department shall allocate an amount equal to the  
136 federal share of the 5311(f) program from amounts calculated  
137 pursuant to s. 206.46(3).

138 2. Notwithstanding the provisions of subparagraph 1., the  
139 department shall allocate at least 50 percent of any new  
140 discretionary highway capacity funds to the Florida Strategic  
141 Intermodal System created pursuant to s. 339.61. Any remaining  
142 new discretionary highway capacity funds shall be allocated to  
143 the districts for new construction as provided in subparagraph  
144 1. For the purposes of this subparagraph, the term "new  
145 discretionary highway capacity funds" means any funds available

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146 to the department above the prior year funding level for  
147 capacity improvements, which the department has the discretion  
148 to allocate to highway projects.

149 ~~3. Notwithstanding subparagraphs 1. and 2. and ss.~~  
150 ~~206.46(3) and 334.044(26), and for fiscal years 2009-2010~~  
151 ~~through 2013-2014 only, the department shall annually allocate~~  
152 ~~up to \$15 million of the first proceeds of the increased~~  
153 ~~revenues estimated by the November 2009 Revenue Estimating~~  
154 ~~Conference to be deposited into the State Transportation Trust~~  
155 ~~Fund to provide for the portion of the transfer of funds~~  
156 ~~included in s. 343.58(4)(a)1.a. or 2.a., as applicable. The~~  
157 ~~transfer of funds included in s. 343.58(4) shall not negatively~~  
158 ~~impact projects included in fiscal years 2009-2010 through 2013-~~  
159 ~~2014 of the work program as of July 1, 2009, as amended pursuant~~  
160 ~~to subsection (7). This subparagraph expires July 1, 2014.~~

161 Reviser's note.—Amended to delete subparagraph (4)(a)3., which  
162 expired pursuant to its own terms, effective July 1, 2014.

163 Section 11. Section 381.0407, Florida Statutes, is  
164 repealed.

165 Reviser's note.—The cited section, the Managed Care and Publicly  
166 Funded Primary Care Program Coordination Act, was repealed  
167 by s. 51, ch. 2012-184, effective October 1, 2014. Since  
168 the section was not repealed by a "current session" of the  
169 Legislature, it may be omitted from the 2015 Florida  
170 Statutes only through a reviser's bill duly enacted by the  
171 Legislature. See s. 11.242(5)(b) and (i).

172 Section 12. Paragraph (f) of subsection (1) of section  
173 403.709, Florida Statutes, is repealed.

174 Reviser's note.—The cited paragraph, which relates to transfer

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175 of moneys, for the 2013-2014 fiscal year only, from the  
176 Solid Waste Management Trust Fund to the Save Our  
177 Everglades Trust Fund for Everglades restoration pursuant  
178 to s. 216.181(12), expired pursuant to its own terms,  
179 effective July 1, 2014.

180 Section 13. Subsection (10) of section 409.911, Florida  
181 Statutes, is repealed.

182 Reviser's note.—The cited subsection, which relates to the  
183 Medicaid Low-Income Pool Council, expired pursuant to its  
184 own terms, effective October 1, 2014.

185 Section 14. Section 409.912, Florida Statutes, is amended  
186 to read:

187 409.912 Cost-effective purchasing of health care.—The  
188 agency shall purchase goods and services for Medicaid recipients  
189 in the most cost-effective manner consistent with the delivery  
190 of quality medical care. To ensure that medical services are  
191 effectively utilized, the agency may, in any case, require a  
192 confirmation or second physician's opinion of the correct  
193 diagnosis for purposes of authorizing future services under the  
194 Medicaid program. This section does not restrict access to  
195 emergency services or poststabilization care services as defined  
196 in 42 C.F.R. s. 438.114. Such confirmation or second opinion  
197 shall be rendered in a manner approved by the agency. The agency  
198 shall maximize the use of prepaid per capita and prepaid  
199 aggregate fixed-sum basis services when appropriate and other  
200 alternative service delivery and reimbursement methodologies,  
201 including competitive bidding pursuant to s. 287.057, designed  
202 to facilitate the cost-effective purchase of a case-managed  
203 continuum of care. The agency shall also require providers to

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204 minimize the exposure of recipients to the need for acute  
205 inpatient, custodial, and other institutional care and the  
206 inappropriate or unnecessary use of high-cost services. The  
207 agency shall contract with a vendor to monitor and evaluate the  
208 clinical practice patterns of providers in order to identify  
209 trends that are outside the normal practice patterns of a  
210 provider's professional peers or the national guidelines of a  
211 provider's professional association. The vendor must be able to  
212 provide information and counseling to a provider whose practice  
213 patterns are outside the norms, in consultation with the agency,  
214 to improve patient care and reduce inappropriate utilization.  
215 The agency may mandate prior authorization, drug therapy  
216 management, or disease management participation for certain  
217 populations of Medicaid beneficiaries, certain drug classes, or  
218 particular drugs to prevent fraud, abuse, overuse, and possible  
219 dangerous drug interactions. The Pharmaceutical and Therapeutics  
220 Committee shall make recommendations to the agency on drugs for  
221 which prior authorization is required. The agency shall inform  
222 the Pharmaceutical and Therapeutics Committee of its decisions  
223 regarding drugs subject to prior authorization. The agency is  
224 authorized to limit the entities it contracts with or enrolls as  
225 Medicaid providers by developing a provider network through  
226 provider credentialing. The agency may competitively bid single-  
227 source-provider contracts if procurement of goods or services  
228 results in demonstrated cost savings to the state without  
229 limiting access to care. The agency may limit its network based  
230 on the assessment of beneficiary access to care, provider  
231 availability, provider quality standards, time and distance  
232 standards for access to care, the cultural competence of the



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233 provider network, demographic characteristics of Medicaid  
234 beneficiaries, practice and provider-to-beneficiary standards,  
235 appointment wait times, beneficiary use of services, provider  
236 turnover, provider profiling, provider licensure history,  
237 previous program integrity investigations and findings, peer  
238 review, provider Medicaid policy and billing compliance records,  
239 clinical and medical record audits, and other factors. Providers  
240 are not entitled to enrollment in the Medicaid provider network.  
241 The agency shall determine instances in which allowing Medicaid  
242 beneficiaries to purchase durable medical equipment and other  
243 goods is less expensive to the Medicaid program than long-term  
244 rental of the equipment or goods. The agency may establish rules  
245 to facilitate purchases in lieu of long-term rentals in order to  
246 protect against fraud and abuse in the Medicaid program as  
247 defined in s. 409.913. The agency may seek federal waivers  
248 necessary to administer these policies.

249 ~~(1) The agency shall work with the Department of Children~~  
250 ~~and Families to ensure access of children and families in the~~  
251 ~~child protection system to needed and appropriate mental health~~  
252 ~~and substance abuse services. This subsection expires October 1,~~  
253 ~~2014.~~

254 ~~(2)~~ The agency may enter into agreements with appropriate  
255 agents of other state agencies or of any agency of the Federal  
256 Government and accept such duties in respect to social welfare  
257 or public aid as may be necessary to implement the provisions of  
258 Title XIX of the Social Security Act and ss. 409.901-409.920.  
259 This subsection expires October 1, 2016.

260 ~~(3) The agency may contract with health maintenance~~  
261 ~~organizations certified pursuant to part I of chapter 641 for~~

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262 ~~the provision of services to recipients. This subsection expires~~  
263 ~~October 1, 2014.~~

264 (2)~~(4)~~ The agency may contract with:

265 ~~(a) An entity that provides no prepaid health care services~~  
266 ~~other than Medicaid services under contract with the agency and~~  
267 ~~which is owned and operated by a county, county health~~  
268 ~~department, or county-owned and operated hospital to provide~~  
269 ~~health care services on a prepaid or fixed-sum basis to~~  
270 ~~recipients, which entity may provide such prepaid services~~  
271 ~~either directly or through arrangements with other providers.~~  
272 ~~Such prepaid health care services entities must be licensed~~  
273 ~~under parts I and III of chapter 641. An entity recognized under~~  
274 ~~this paragraph which demonstrates to the satisfaction of the~~  
275 ~~Office of Insurance Regulation of the Financial Services~~  
276 ~~Commission that it is backed by the full faith and credit of the~~  
277 ~~county in which it is located may be exempted from s. 641.225.~~  
278 ~~This paragraph expires October 1, 2014.~~

279 ~~(b) An entity that is providing comprehensive behavioral~~  
280 ~~health care services to certain Medicaid recipients through a~~  
281 ~~capitated, prepaid arrangement pursuant to the federal waiver~~  
282 ~~provided for by s. 409.905(5). Such entity must be licensed~~  
283 ~~under chapter 624, chapter 636, or chapter 641, or authorized~~  
284 ~~under paragraph (c) or paragraph (d), and must possess the~~  
285 ~~clinical systems and operational competence to manage risk and~~  
286 ~~provide comprehensive behavioral health care to Medicaid~~  
287 ~~recipients. As used in this paragraph, the term "comprehensive~~  
288 ~~behavioral health care services" means covered mental health and~~  
289 ~~substance abuse treatment services that are available to~~  
290 ~~Medicaid recipients. The secretary of the Department of Children~~

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291 ~~and Families shall approve provisions of procurements related to~~  
292 ~~children in the department's care or custody before enrolling~~  
293 ~~such children in a prepaid behavioral health plan. Any contract~~  
294 ~~awarded under this paragraph must be competitively procured. In~~  
295 ~~developing the behavioral health care prepaid plan procurement~~  
296 ~~document, the agency shall ensure that the procurement document~~  
297 ~~requires the contractor to develop and implement a plan to~~  
298 ~~ensure compliance with s. 394.4574 related to services provided~~  
299 ~~to residents of licensed assisted living facilities that hold a~~  
300 ~~limited mental health license. Except as provided in~~  
301 ~~subparagraph 5., and except in counties where the Medicaid~~  
302 ~~managed care pilot program is authorized pursuant to s.~~  
303 ~~409.91211, the agency shall seek federal approval to contract~~  
304 ~~with a single entity meeting these requirements to provide~~  
305 ~~comprehensive behavioral health care services to all Medicaid~~  
306 ~~recipients not enrolled in a Medicaid managed care plan~~  
307 ~~authorized under s. 409.91211, a provider service network~~  
308 ~~authorized under paragraph (d), or a Medicaid health maintenance~~  
309 ~~organization in an AHCA area. In an AHCA area where the Medicaid~~  
310 ~~managed care pilot program is authorized pursuant to s.~~  
311 ~~409.91211 in one or more counties, the agency may procure a~~  
312 ~~contract with a single entity to serve the remaining counties as~~  
313 ~~an AHCA area or the remaining counties may be included with an~~  
314 ~~adjacent AHCA area and are subject to this paragraph. Each~~  
315 ~~entity must offer a sufficient choice of providers in its~~  
316 ~~network to ensure recipient access to care and the opportunity~~  
317 ~~to select a provider with whom they are satisfied. The network~~  
318 ~~shall include all public mental health hospitals. To ensure~~  
319 ~~unimpaired access to behavioral health care services by Medicaid~~

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320 ~~recipients, all contracts issued pursuant to this paragraph must~~  
321 ~~require 80 percent of the capitation paid to the managed care~~  
322 ~~plan, including health maintenance organizations and capitated~~  
323 ~~provider service networks, to be expended for the provision of~~  
324 ~~behavioral health care services. If the managed care plan~~  
325 ~~expends less than 80 percent of the capitation paid for the~~  
326 ~~provision of behavioral health care services, the difference~~  
327 ~~shall be returned to the agency. The agency shall provide the~~  
328 ~~plan with a certification letter indicating the amount of~~  
329 ~~capitation paid during each calendar year for behavioral health~~  
330 ~~care services pursuant to this section. The agency may reimburse~~  
331 ~~for substance abuse treatment services on a fee-for-service~~  
332 ~~basis until the agency finds that adequate funds are available~~  
333 ~~for capitated, prepaid arrangements.~~

334 ~~1. The agency shall modify the contracts with the entities~~  
335 ~~providing comprehensive inpatient and outpatient mental health~~  
336 ~~care services to Medicaid recipients in Hillsborough, Highlands,~~  
337 ~~Hardee, Manatee, and Polk Counties, to include substance abuse~~  
338 ~~treatment services.~~

339 ~~2. Except as provided in subparagraph 5., the agency and~~  
340 ~~the Department of Children and Families shall contract with~~  
341 ~~managed care entities in each AHCA area except area 6 or arrange~~  
342 ~~to provide comprehensive inpatient and outpatient mental health~~  
343 ~~and substance abuse services through capitated prepaid~~  
344 ~~arrangements to all Medicaid recipients who are eligible to~~  
345 ~~participate in such plans under federal law and regulation. In~~  
346 ~~AHCA areas where eligible individuals number less than 150,000,~~  
347 ~~the agency shall contract with a single managed care plan to~~  
348 ~~provide comprehensive behavioral health services to all~~

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349 ~~recipients who are not enrolled in a Medicaid health maintenance~~  
350 ~~organization, a provider service network authorized under~~  
351 ~~paragraph (d), or a Medicaid capitated managed care plan~~  
352 ~~authorized under s. 409.91211. The agency may contract with more~~  
353 ~~than one comprehensive behavioral health provider to provide~~  
354 ~~care to recipients who are not enrolled in a Medicaid capitated~~  
355 ~~managed care plan authorized under s. 409.91211, a provider~~  
356 ~~service network authorized under paragraph (d), or a Medicaid~~  
357 ~~health maintenance organization in AHCA areas where the eligible~~  
358 ~~population exceeds 150,000. In an AHCA area where the Medicaid~~  
359 ~~managed care pilot program is authorized pursuant to s.~~  
360 ~~409.91211 in one or more counties, the agency may procure a~~  
361 ~~contract with a single entity to serve the remaining counties as~~  
362 ~~an AHCA area or the remaining counties may be included with an~~  
363 ~~adjacent AHCA area and shall be subject to this paragraph.~~  
364 ~~Contracts for comprehensive behavioral health providers awarded~~  
365 ~~pursuant to this section shall be competitively procured. Both~~  
366 ~~for-profit and not-for-profit corporations are eligible to~~  
367 ~~compete. Managed care plans contracting with the agency under~~  
368 ~~subsection (3) or paragraph (d) shall provide and receive~~  
369 ~~payment for the same comprehensive behavioral health benefits as~~  
370 ~~provided in AHCA rules, including handbooks incorporated by~~  
371 ~~reference. In AHCA area 11, the agency shall contract with at~~  
372 ~~least two comprehensive behavioral health care providers to~~  
373 ~~provide behavioral health care to recipients in that area who~~  
374 ~~are enrolled in, or assigned to, the MediPass program. One of~~  
375 ~~the behavioral health care contracts must be with the existing~~  
376 ~~provider service network pilot project, as described in~~  
377 ~~paragraph (d), for the purpose of demonstrating the cost-~~

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378 ~~effectiveness of the provision of quality mental health services~~  
379 ~~through a public hospital-operated managed care model. Payment~~  
380 ~~shall be at an agreed-upon capitated rate to ensure cost~~  
381 ~~savings. Of the recipients in area 11 who are assigned to~~  
382 ~~MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those~~  
383 ~~MediPass-enrolled recipients shall be assigned to the existing~~  
384 ~~provider service network in area 11 for their behavioral care.~~

385 ~~3. Children residing in a statewide inpatient psychiatric~~  
386 ~~program, or in a Department of Juvenile Justice or a Department~~  
387 ~~of Children and Families residential program approved as a~~  
388 ~~Medicaid behavioral health overlay services provider may not be~~  
389 ~~included in a behavioral health care prepaid health plan or any~~  
390 ~~other Medicaid managed care plan pursuant to this paragraph.~~

391 ~~4. Traditional community mental health providers under~~  
392 ~~contract with the Department of Children and Families pursuant~~  
393 ~~to part IV of chapter 394, child welfare providers under~~  
394 ~~contract with the Department of Children and Families in areas 1~~  
395 ~~and 6, and inpatient mental health providers licensed pursuant~~  
396 ~~to chapter 395 must be offered an opportunity to accept or~~  
397 ~~decline a contract to participate in any provider network for~~  
398 ~~prepaid behavioral health services.~~

399 ~~5. All Medicaid-eligible children, except children in area~~  
400 ~~1 and children in Highlands County, Hardee County, Polk County,~~  
401 ~~or Manatee County of area 6, which are open for child welfare~~  
402 ~~services in the statewide automated child welfare information~~  
403 ~~system, shall receive their behavioral health care services~~  
404 ~~through a specialty prepaid plan operated by community-based~~  
405 ~~lead agencies through a single agency or formal agreements among~~  
406 ~~several agencies. The agency shall work with the specialty plan~~

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407 ~~to develop clinically effective, evidence-based alternatives as~~  
408 ~~a downward substitution for the statewide inpatient psychiatric~~  
409 ~~program and similar residential care and institutional services.~~  
410 ~~The specialty prepaid plan must result in savings to the state~~  
411 ~~comparable to savings achieved in other Medicaid managed care~~  
412 ~~and prepaid programs. Such plan must provide mechanisms to~~  
413 ~~maximize state and local revenues. The specialty prepaid plan~~  
414 ~~shall be developed by the agency and the Department of Children~~  
415 ~~and Families. The agency may seek federal waivers to implement~~  
416 ~~this initiative. Medicaid-eligible children whose cases are open~~  
417 ~~for child welfare services in the statewide automated child~~  
418 ~~welfare information system and who reside in AHCA area 10 shall~~  
419 ~~be enrolled in a capitated provider service network or other~~  
420 ~~capitated managed care plan, which, in coordination with~~  
421 ~~available community-based care providers specified in s.~~  
422 ~~409.987, shall provide sufficient medical, developmental, and~~  
423 ~~behavioral health services to meet the needs of these children.~~

424  
425 ~~Effective July 1, 2012, in order to ensure continuity of care,~~  
426 ~~the agency is authorized to extend or modify current contracts~~  
427 ~~based on current service areas or on a regional basis, as~~  
428 ~~determined appropriate by the agency, with comprehensive~~  
429 ~~behavioral health care providers as described in this paragraph~~  
430 ~~during the period prior to its expiration. This paragraph~~  
431 ~~expires October 1, 2014.~~

432 ~~(c) A federally qualified health center or an entity owned~~  
433 ~~by one or more federally qualified health centers or an entity~~  
434 ~~owned by other migrant and community health centers receiving~~  
435 ~~non-Medicaid financial support from the Federal Government to~~

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436 ~~provide health care services on a prepaid or fixed sum basis to~~  
437 ~~recipients. A federally qualified health center or an entity~~  
438 ~~that is owned by one or more federally qualified health centers~~  
439 ~~and is reimbursed by the agency on a prepaid basis is exempt~~  
440 ~~from parts I and III of chapter 641, but must comply with the~~  
441 ~~solvency requirements in s. 641.2261(2) and meet the appropriate~~  
442 ~~requirements governing financial reserve, quality assurance, and~~  
443 ~~patients' rights established by the agency. This paragraph~~  
444 ~~expires October 1, 2014.~~

445 ~~(d)1.~~ a provider service network, which may be reimbursed  
446 on a fee-for-service or prepaid basis. Prepaid provider service  
447 networks shall receive per-member, per-month payments. A  
448 provider service network that does not choose to be a prepaid  
449 plan shall receive fee-for-service rates with a shared savings  
450 settlement. The fee-for-service option shall be available to a  
451 provider service network only for the first 2 years of the  
452 plan's operation or until the contract year beginning September  
453 1, 2014, whichever is later. The agency shall annually conduct  
454 cost reconciliations to determine the amount of cost savings  
455 achieved by fee-for-service provider service networks for the  
456 dates of service in the period being reconciled. Only payments  
457 for covered services for dates of service within the  
458 reconciliation period and paid within 6 months after the last  
459 date of service in the reconciliation period shall be included.  
460 The agency shall perform the necessary adjustments for the  
461 inclusion of claims incurred but not reported within the  
462 reconciliation for claims that could be received and paid by the  
463 agency after the 6-month claims processing time lag. The agency  
464 shall provide the results of the reconciliations to the fee-for-



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465 service provider service networks within 45 days after the end  
466 of the reconciliation period. The fee-for-service provider  
467 service networks shall review and provide written comments or a  
468 letter of concurrence to the agency within 45 days after receipt  
469 of the reconciliation results. This reconciliation shall be  
470 considered final.

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

477 ~~3. Medicaid recipients assigned to a provider service~~  
478 ~~network shall be chosen equally from those who would otherwise~~  
479 ~~have been assigned to prepaid plans and MediPass. The agency is~~  
480 ~~authorized to seek federal Medicaid waivers as necessary to~~  
481 ~~implement the provisions of this section. This subparagraph~~  
482 ~~expires October 1, 2014.~~

483 (b)4. A provider service network is a network established  
484 or organized and operated by a health care provider, or group of  
485 affiliated health care providers, ~~including minority physician~~  
486 ~~networks and emergency room diversion programs that meet the~~  
487 ~~requirements of s. 409.91211,~~ which provides a substantial  
488 proportion of the health care items and services under a  
489 contract directly through the provider or affiliated group of  
490 providers and may make arrangements with physicians or other  
491 health care professionals, health care institutions, or any  
492 combination of such individuals or institutions to assume all or  
493 part of the financial risk on a prospective basis for the

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494 provision of basic health services by the physicians, by other  
495 health professionals, or through the institutions. The health  
496 care providers must have a controlling interest in the governing  
497 body of the provider service network organization.

498 ~~(e) An entity that provides only comprehensive behavioral~~  
499 ~~health care services to certain Medicaid recipients through an~~  
500 ~~administrative services organization agreement. Such an entity~~  
501 ~~must possess the clinical systems and operational competence to~~  
502 ~~provide comprehensive health care to Medicaid recipients. As~~  
503 ~~used in this paragraph, the term "comprehensive behavioral~~  
504 ~~health care services" means covered mental health and substance~~  
505 ~~abuse treatment services that are available to Medicaid~~  
506 ~~recipients. Any contract awarded under this paragraph must be~~  
507 ~~competitively procured. The agency must ensure that Medicaid~~  
508 ~~recipients have available the choice of at least two managed~~  
509 ~~care plans for their behavioral health care services. This~~  
510 ~~paragraph expires October 1, 2014.~~

511 ~~(f) An entity authorized in s. 430.205 to contract with the~~  
512 ~~agency and the Department of Elderly Affairs to provide health~~  
513 ~~care and social services on a prepaid or fixed-sum basis to~~  
514 ~~elderly recipients. Such prepaid health care services entities~~  
515 ~~are exempt from the provisions of part I of chapter 641 for the~~  
516 ~~first 3 years of operation. An entity recognized under this~~  
517 ~~paragraph that demonstrates to the satisfaction of the Office of~~  
518 ~~Insurance Regulation that it is backed by the full faith and~~  
519 ~~credit of one or more counties in which it operates may be~~  
520 ~~exempted from s. 641.225. This paragraph expires October 1,~~  
521 ~~2013.~~

522 ~~(g) A Children's Medical Services Network, as defined in s.~~

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523 ~~391.021. This paragraph expires October 1, 2014.~~

524 ~~(5) The agency may contract with any public or private~~  
525 ~~entity otherwise authorized by this section on a prepaid or~~  
526 ~~fixed sum basis for the provision of health care services to~~  
527 ~~recipients. An entity may provide prepaid services to~~  
528 ~~recipients, either directly or through arrangements with other~~  
529 ~~entities, if each entity involved in providing services:~~

530 ~~(a) Is organized primarily for the purpose of providing~~  
531 ~~health care or other services of the type regularly offered to~~  
532 ~~Medicaid recipients;~~

533 ~~(b) Ensures that services meet the standards set by the~~  
534 ~~agency for quality, appropriateness, and timeliness;~~

535 ~~(c) Makes provisions satisfactory to the agency for~~  
536 ~~insolvency protection and ensures that neither enrolled Medicaid~~  
537 ~~recipients nor the agency will be liable for the debts of the~~  
538 ~~entity;~~

539 ~~(d) Submits to the agency, if a private entity, a financial~~  
540 ~~plan that the agency finds to be fiscally sound and that~~  
541 ~~provides for working capital in the form of cash or equivalent~~  
542 ~~liquid assets excluding revenues from Medicaid premium payments~~  
543 ~~equal to at least the first 3 months of operating expenses or~~  
544 ~~\$200,000, whichever is greater;~~

545 ~~(e) Furnishes evidence satisfactory to the agency of~~  
546 ~~adequate liability insurance coverage or an adequate plan of~~  
547 ~~self-insurance to respond to claims for injuries arising out of~~  
548 ~~the furnishing of health care;~~

549 ~~(f) Provides, through contract or otherwise, for periodic~~  
550 ~~review of its medical facilities and services, as required by~~  
551 ~~the agency; and~~

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552 ~~(g) Provides organizational, operational, financial, and~~  
553 ~~other information required by the agency.~~

554

555 ~~This subsection expires October 1, 2014.~~

556 ~~(6) The agency may contract on a prepaid or fixed sum basis~~  
557 ~~with any health insurer that:~~

558 ~~(a) Pays for health care services provided to enrolled~~  
559 ~~Medicaid recipients in exchange for a premium payment paid by~~  
560 ~~the agency;~~

561 ~~(b) Assumes the underwriting risk; and~~

562 ~~(c) Is organized and licensed under applicable provisions~~  
563 ~~of the Florida Insurance Code and is currently in good standing~~  
564 ~~with the Office of Insurance Regulation.~~

565

566 ~~This subsection expires October 1, 2014.~~

567 ~~(7) The agency may contract on a prepaid or fixed sum basis~~  
568 ~~with an exclusive provider organization to provide health care~~  
569 ~~services to Medicaid recipients provided that the exclusive~~  
570 ~~provider organization meets applicable managed care plan~~  
571 ~~requirements in this section, ss. 409.9122, 409.9123, 409.9128,~~  
572 ~~and 627.6472, and other applicable provisions of law. This~~  
573 ~~subsection expires October 1, 2014.~~

574 ~~(8) The Agency for Health Care Administration may provide~~  
575 ~~cost-effective purchasing of chiropractic services on a fee-for-~~  
576 ~~service basis to Medicaid recipients through arrangements with a~~  
577 ~~statewide chiropractic preferred provider organization~~  
578 ~~incorporated in this state as a not-for-profit corporation. The~~  
579 ~~agency shall ensure that the benefit limits and prior~~  
580 ~~authorization requirements in the current Medicaid program shall~~

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581 ~~apply to the services provided by the chiropractic preferred~~  
 582 ~~provider organization. This subsection expires October 1, 2014.~~

583 ~~(9) The agency shall not contract on a prepaid or fixed-sum~~  
 584 ~~basis for Medicaid services with an entity which knows or~~  
 585 ~~reasonably should know that any officer, director, agent,~~  
 586 ~~managing employee, or owner of stock or beneficial interest in~~  
 587 ~~excess of 5 percent common or preferred stock, or the entity~~  
 588 ~~itself, has been found guilty of, regardless of adjudication, or~~  
 589 ~~entered a plea of nolo contendere, or guilty, to:~~

590 ~~(a) Fraud;~~

591 ~~(b) Violation of federal or state antitrust statutes,~~  
 592 ~~including those proscribing price fixing between competitors and~~  
 593 ~~the allocation of customers among competitors;~~

594 ~~(c) Commission of a felony involving embezzlement, theft,~~  
 595 ~~forgery, income tax evasion, bribery, falsification or~~  
 596 ~~destruction of records, making false statements, receiving~~  
 597 ~~stolen property, making false claims, or obstruction of justice;~~  
 598 ~~or~~

599 ~~(d) Any crime in any jurisdiction which directly relates to~~  
 600 ~~the provision of health services on a prepaid or fixed-sum~~  
 601 ~~basis.~~

602

603 ~~This subsection expires October 1, 2014.~~

604 (3) ~~(10)~~ The agency, after notifying the Legislature, may  
 605 apply for waivers of applicable federal laws and regulations as  
 606 necessary to implement more appropriate systems of health care  
 607 for Medicaid recipients and reduce the cost of the Medicaid  
 608 program to the state and federal governments and shall implement  
 609 such programs, after legislative approval, within a reasonable

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610 period of time after federal approval. These programs must be  
611 designed primarily to reduce the need for inpatient care,  
612 custodial care and other long-term or institutional care, and  
613 other high-cost services. Prior to seeking legislative approval  
614 of such a waiver as authorized by this subsection, the agency  
615 shall provide notice and an opportunity for public comment.  
616 Notice shall be provided to all persons who have made requests  
617 of the agency for advance notice and shall be published in the  
618 Florida Administrative Register not less than 28 days prior to  
619 the intended action. This subsection expires October 1, 2016.

620 ~~(11) The agency shall establish a postpayment utilization~~  
621 ~~control program designed to identify recipients who may~~  
622 ~~inappropriately overuse or underuse Medicaid services and shall~~  
623 ~~provide methods to correct such misuse. This subsection expires~~  
624 ~~October 1, 2014.~~

625 ~~(12) The agency shall develop and provide coordinated~~  
626 ~~systems of care for Medicaid recipients and may contract with~~  
627 ~~public or private entities to develop and administer such~~  
628 ~~systems of care among public and private health care providers~~  
629 ~~in a given geographic area. This subsection expires October 1,~~  
630 ~~2014.~~

631 ~~(13) The agency shall operate or contract for the operation~~  
632 ~~of utilization management and incentive systems designed to~~  
633 ~~encourage cost-effective use of services and to eliminate~~  
634 ~~services that are medically unnecessary. The agency shall track~~  
635 ~~Medicaid provider prescription and billing patterns and evaluate~~  
636 ~~them against Medicaid medical necessity criteria and coverage~~  
637 ~~and limitation guidelines adopted by rule. Medical necessity~~  
638 ~~determination requires that service be consistent with symptoms~~

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639 ~~or confirmed diagnosis of illness or injury under treatment and~~  
640 ~~not in excess of the patient's needs. The agency shall conduct~~  
641 ~~reviews of provider exceptions to peer group norms and shall,~~  
642 ~~using statistical methodologies, provider profiling, and~~  
643 ~~analysis of billing patterns, detect and investigate abnormal or~~  
644 ~~unusual increases in billing or payment of claims for Medicaid~~  
645 ~~services and medically unnecessary provision of services.~~  
646 ~~Providers that demonstrate a pattern of submitting claims for~~  
647 ~~medically unnecessary services shall be referred to the Medicaid~~  
648 ~~program integrity unit for investigation. In its annual report,~~  
649 ~~required in s. 409.913, the agency shall report on its efforts~~  
650 ~~to control overutilization as described in this subsection. This~~  
651 ~~subsection expires October 1, 2014.~~

652 ~~(14) (a) The agency shall operate the Comprehensive~~  
653 ~~Assessment and Review for Long Term Care Services (CARES)~~  
654 ~~nursing facility preadmission screening program to ensure that~~  
655 ~~Medicaid payment for nursing facility care is made only for~~  
656 ~~individuals whose conditions require such care and to ensure~~  
657 ~~that long-term care services are provided in the setting most~~  
658 ~~appropriate to the needs of the person and in the most~~  
659 ~~economical manner possible. The CARES program shall also ensure~~  
660 ~~that individuals participating in Medicaid home and community-~~  
661 ~~based waiver programs meet criteria for those programs,~~  
662 ~~consistent with approved federal waivers.~~

663 ~~(b) The agency shall operate the CARES program through an~~  
664 ~~interagency agreement with the Department of Elderly Affairs.~~  
665 ~~The agency, in consultation with the Department of Elderly~~  
666 ~~Affairs, may contract for any function or activity of the CARES~~  
667 ~~program, including any function or activity required by 42~~

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668 ~~C.F.R. s. 483.20, relating to preadmission screening and~~  
669 ~~resident review.~~

670 ~~(c) Prior to making payment for nursing facility services~~  
671 ~~for a Medicaid recipient, the agency must verify that the~~  
672 ~~nursing facility preadmission screening program has determined~~  
673 ~~that the individual requires nursing facility care and that the~~  
674 ~~individual cannot be safely served in community-based programs.~~  
675 ~~The nursing facility preadmission screening program shall refer~~  
676 ~~a Medicaid recipient to a community-based program if the~~  
677 ~~individual could be safely served at a lower cost and the~~  
678 ~~recipient chooses to participate in such program. For~~  
679 ~~individuals whose nursing home stay is initially funded by~~  
680 ~~Medicare and Medicare coverage is being terminated for lack of~~  
681 ~~progress towards rehabilitation, CARES staff shall consult with~~  
682 ~~the person making the determination of progress toward~~  
683 ~~rehabilitation to ensure that the recipient is not being~~  
684 ~~inappropriately disqualified from Medicare coverage. If, in~~  
685 ~~their professional judgment, CARES staff believes that a~~  
686 ~~Medicare beneficiary is still making progress toward~~  
687 ~~rehabilitation, they may assist the Medicare beneficiary with an~~  
688 ~~appeal of the disqualification from Medicare coverage. The use~~  
689 ~~of CARES teams to review Medicare denials for coverage under~~  
690 ~~this section is authorized only if it is determined that such~~  
691 ~~reviews qualify for federal matching funds through Medicaid. The~~  
692 ~~agency shall seek or amend federal waivers as necessary to~~  
693 ~~implement this section.~~

694 ~~(d) For the purpose of initiating immediate prescreening~~  
695 ~~and diversion assistance for individuals residing in nursing~~  
696 ~~homes and in order to make families aware of alternative long-~~



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697 ~~term care resources so that they may choose a more cost-~~  
698 ~~effective setting for long-term placement, CARES staff shall~~  
699 ~~conduct an assessment and review of a sample of individuals~~  
700 ~~whose nursing home stay is expected to exceed 20 days,~~  
701 ~~regardless of the initial funding source for the nursing home~~  
702 ~~placement. CARES staff shall provide counseling and referral~~  
703 ~~services to these individuals regarding choosing appropriate~~  
704 ~~long-term care alternatives. This paragraph does not apply to~~  
705 ~~continuing care facilities licensed under chapter 651 or to~~  
706 ~~retirement communities that provide a combination of nursing~~  
707 ~~home, independent living, and other long-term care services.~~

708 ~~(e) By January 15 of each year, the agency shall submit a~~  
709 ~~report to the Legislature describing the operations of the CARES~~  
710 ~~program. The report must describe:~~

711 ~~1. Rate of diversion to community alternative programs;~~

712 ~~2. CARES program staffing needs to achieve additional~~  
713 ~~diversions;~~

714 ~~3. Reasons the program is unable to place individuals in~~  
715 ~~less restrictive settings when such individuals desired such~~  
716 ~~services and could have been served in such settings;~~

717 ~~4. Barriers to appropriate placement, including barriers~~  
718 ~~due to policies or operations of other agencies or state-funded~~  
719 ~~programs; and~~

720 ~~5. Statutory changes necessary to ensure that individuals~~  
721 ~~in need of long-term care services receive care in the least~~  
722 ~~restrictive environment.~~

723 ~~(f) The Department of Elderly Affairs shall track~~  
724 ~~individuals over time who are assessed under the CARES program~~  
725 ~~and who are diverted from nursing home placement. By January 15~~

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726 ~~of each year, the department shall submit to the Legislature a~~  
727 ~~longitudinal study of the individuals who are diverted from~~  
728 ~~nursing home placement. The study must include:~~

729 ~~1. The demographic characteristics of the individuals~~  
730 ~~assessed and diverted from nursing home placement, including,~~  
731 ~~but not limited to, age, race, gender, frailty, caregiver~~  
732 ~~status, living arrangements, and geographic location;~~

733 ~~2. A summary of community services provided to individuals~~  
734 ~~for 1 year after assessment and diversion;~~

735 ~~3. A summary of inpatient hospital admissions for~~  
736 ~~individuals who have been diverted; and~~

737 ~~4. A summary of the length of time between diversion and~~  
738 ~~subsequent entry into a nursing home or death.~~

739  
740 ~~This subsection expires October 1, 2013.~~

741 ~~(15) (a) The agency shall identify health care utilization~~  
742 ~~and price patterns within the Medicaid program which are not~~  
743 ~~cost-effective or medically appropriate and assess the~~  
744 ~~effectiveness of new or alternate methods of providing and~~  
745 ~~monitoring service, and may implement such methods as it~~  
746 ~~considers appropriate. Such methods may include disease~~  
747 ~~management initiatives, an integrated and systematic approach~~  
748 ~~for managing the health care needs of recipients who are at risk~~  
749 ~~of or diagnosed with a specific disease by using best practices,~~  
750 ~~prevention strategies, clinical-practice improvement, clinical~~  
751 ~~interventions and protocols, outcomes research, information~~  
752 ~~technology, and other tools and resources to reduce overall~~  
753 ~~costs and improve measurable outcomes.~~

754 ~~(b) The responsibility of the agency under this subsection~~

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755 ~~includes the development of capabilities to identify actual and~~  
756 ~~optimal practice patterns; patient and provider educational~~  
757 ~~initiatives; methods for determining patient compliance with~~  
758 ~~prescribed treatments; fraud, waste, and abuse prevention and~~  
759 ~~detection programs; and beneficiary case management programs.~~

760 ~~1. The practice pattern identification program shall~~  
761 ~~evaluate practitioner prescribing patterns based on national and~~  
762 ~~regional practice guidelines, comparing practitioners to their~~  
763 ~~peer groups. The agency and its Drug Utilization Review Board~~  
764 ~~shall consult with the Department of Health and a panel of~~  
765 ~~practicing health care professionals consisting of the~~  
766 ~~following: the Speaker of the House of Representatives and the~~  
767 ~~President of the Senate shall each appoint three physicians~~  
768 ~~licensed under chapter 458 or chapter 459, and the Governor~~  
769 ~~shall appoint two pharmacists licensed under chapter 465 and one~~  
770 ~~dentist licensed under chapter 466 who is an oral surgeon. Terms~~  
771 ~~of the panel members shall expire at the discretion of the~~  
772 ~~appointing official. The advisory panel shall be responsible for~~  
773 ~~evaluating treatment guidelines and recommending ways to~~  
774 ~~incorporate their use in the practice pattern identification~~  
775 ~~program. Practitioners who are prescribing inappropriately or~~  
776 ~~inefficiently, as determined by the agency, may have their~~  
777 ~~prescribing of certain drugs subject to prior authorization or~~  
778 ~~may be terminated from all participation in the Medicaid~~  
779 ~~program.~~

780 ~~2. The agency shall also develop educational interventions~~  
781 ~~designed to promote the proper use of medications by providers~~  
782 ~~and beneficiaries.~~

783 ~~3. The agency shall implement a pharmacy fraud, waste, and~~

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784 ~~abuse initiative that may include a surety bond or letter of~~  
785 ~~credit requirement for participating pharmacies, enhanced~~  
786 ~~provider auditing practices, the use of additional fraud and~~  
787 ~~abuse software, recipient management programs for beneficiaries~~  
788 ~~inappropriately using their benefits, and other steps that~~  
789 ~~eliminate provider and recipient fraud, waste, and abuse. The~~  
790 ~~initiative shall address enforcement efforts to reduce the~~  
791 ~~number and use of counterfeit prescriptions.~~

792 ~~4. The agency may contract with an entity in the state to~~  
793 ~~provide Medicaid providers with electronic access to Medicaid~~  
794 ~~prescription refill data and information relating to the~~  
795 ~~Medicaid preferred drug list. The initiative shall be designed~~  
796 ~~to enhance the agency's efforts to reduce fraud, abuse, and~~  
797 ~~errors in the prescription drug benefit program and to otherwise~~  
798 ~~further the intent of this paragraph.~~

799 ~~5. The agency shall contract with an entity to design a~~  
800 ~~database of clinical utilization information or electronic~~  
801 ~~medical records for Medicaid providers. The database must be~~  
802 ~~web-based and allow providers to review on a real-time basis the~~  
803 ~~utilization of Medicaid services, including, but not limited to,~~  
804 ~~physician office visits, inpatient and outpatient~~  
805 ~~hospitalizations, laboratory and pathology services,~~  
806 ~~radiological and other imaging services, dental care, and~~  
807 ~~patterns of dispensing prescription drugs in order to coordinate~~  
808 ~~care and identify potential fraud and abuse.~~

809 ~~6. The agency may apply for any federal waivers needed to~~  
810 ~~administer this paragraph.~~

811  
812 ~~This subsection expires October 1, 2014.~~

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813       ~~(16) An entity contracting on a prepaid or fixed-sum basis~~  
814 ~~shall meet the surplus requirements of s. 641.225. If an~~  
815 ~~entity's surplus falls below an amount equal to the surplus~~  
816 ~~requirements of s. 641.225, the agency shall prohibit the entity~~  
817 ~~from engaging in marketing and preenrollment activities, shall~~  
818 ~~cease to process new enrollments, and may not renew the entity's~~  
819 ~~contract until the required balance is achieved. The~~  
820 ~~requirements of this subsection do not apply:~~

821       ~~(a) Where a public entity agrees to fund any deficit~~  
822 ~~incurred by the contracting entity; or~~

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

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

827           ~~2. Submits a written guarantee acceptable to the agency~~  
828 ~~which is irrevocable during the term of the contracting entity's~~  
829 ~~contract with the agency and, upon termination of the contract,~~  
830 ~~until the agency receives proof of satisfaction of all~~  
831 ~~outstanding obligations incurred under the contract.~~

832

833 ~~This subsection expires October 1, 2014.~~

834       ~~(4)~~(17) (a) The agency may require an entity contracting on  
835 a prepaid or fixed-sum basis to establish a restricted  
836 insolvency protection account with a federally guaranteed  
837 financial institution licensed to do business in this state. The  
838 entity shall deposit into that account 5 percent of the  
839 capitation payments made by the agency each month until a  
840 maximum total of 2 percent of the total current contract amount  
841 is reached. The restricted insolvency protection account may be

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842 drawn upon with the authorized signatures of two persons  
843 designated by the entity and two representatives of the agency.  
844 If the agency finds that the entity is insolvent, the agency may  
845 draw upon the account solely with the two authorized signatures  
846 of representatives of the agency, and the funds may be disbursed  
847 to meet financial obligations incurred by the entity under the  
848 prepaid contract. If the contract is terminated, expired, or not  
849 continued, the account balance must be released by the agency to  
850 the entity upon receipt of proof of satisfaction of all  
851 outstanding obligations incurred under this contract.

852 (b) The agency may waive the insolvency protection account  
853 requirement in writing when evidence is on file with the agency  
854 of adequate insolvency insurance and reinsurance that will  
855 protect enrollees if the entity becomes unable to meet its  
856 obligations.

857 ~~(18) An entity that contracts with the agency on a prepaid~~  
858 ~~or fixed sum basis for the provision of Medicaid services shall~~  
859 ~~reimburse any hospital or physician that is outside the entity's~~  
860 ~~authorized geographic service area as specified in its contract~~  
861 ~~with the agency, and that provides services authorized by the~~  
862 ~~entity to its members, at a rate negotiated with the hospital or~~  
863 ~~physician for the provision of services or according to the~~  
864 ~~lesser of the following:~~

865 ~~(a) The usual and customary charges made to the general~~  
866 ~~public by the hospital or physician; or~~

867 ~~(b) The Florida Medicaid reimbursement rate established for~~  
868 ~~the hospital or physician.~~

869  
870 ~~This subsection expires October 1, 2014.~~

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871 ~~(19) When a merger or acquisition of a Medicaid prepaid~~  
872 ~~contractor has been approved by the Office of Insurance~~  
873 ~~Regulation pursuant to s. 628.4615, the agency shall approve the~~  
874 ~~assignment or transfer of the appropriate Medicaid prepaid~~  
875 ~~contract upon request of the surviving entity of the merger or~~  
876 ~~acquisition if the contractor and the other entity have been in~~  
877 ~~good standing with the agency for the most recent 12-month~~  
878 ~~period, unless the agency determines that the assignment or~~  
879 ~~transfer would be detrimental to the Medicaid recipients or the~~  
880 ~~Medicaid program. To be in good standing, an entity must not~~  
881 ~~have failed accreditation or committed any material violation of~~  
882 ~~the requirements of s. 641.52 and must meet the Medicaid~~  
883 ~~contract requirements. For purposes of this section, a merger or~~  
884 ~~acquisition means a change in controlling interest of an entity,~~  
885 ~~including an asset or stock purchase. This subsection expires~~  
886 ~~October 1, 2014.~~

887 (5) ~~(20)~~ Any entity contracting with the agency pursuant to  
888 this section to provide health care services to Medicaid  
889 recipients is prohibited from engaging in any of the following  
890 practices or activities:

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

894 (b) Activities that could mislead or confuse recipients, or  
895 misrepresent the organization, its marketing representatives, or  
896 the agency. Violations of this paragraph include, but are not  
897 limited to:

898 1. False or misleading claims that marketing  
899 representatives are employees or representatives of the state or

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900 county, or of anyone other than the entity or the organization  
901 by whom they are reimbursed.

902 2. False or misleading claims that the entity is  
903 recommended or endorsed by any state or county agency, or by any  
904 other organization which has not certified its endorsement in  
905 writing to the entity.

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

908 4. Claims that a Medicaid recipient will lose benefits  
909 under the Medicaid program, or any other health or welfare  
910 benefits to which the recipient is legally entitled, if the  
911 recipient does not enroll with the entity.

912 (c) Granting or offering of any monetary or other valuable  
913 consideration for enrollment, ~~except as authorized by subsection~~  
914 ~~(23)~~.

915 (d) Door-to-door solicitation of recipients who have not  
916 contacted the entity or who have not invited the entity to make  
917 a presentation.

918 (e) Solicitation of Medicaid recipients by marketing  
919 representatives stationed in state offices unless approved and  
920 supervised by the agency or its agent and approved by the  
921 affected state agency when solicitation occurs in an office of  
922 the state agency. The agency shall ensure that marketing  
923 representatives stationed in state offices shall market their  
924 managed care plans to Medicaid recipients only in designated  
925 areas and in such a way as to not interfere with the recipients'  
926 activities in the state office.

927 (f) Enrollment of Medicaid recipients.

928 (6) ~~(21)~~ The agency may impose a fine for a violation of



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929 this section or the contract with the agency by a person or  
930 entity that is under contract with the agency. With respect to  
931 any nonwillful violation, such fine shall not exceed \$2,500 per  
932 violation. In no event shall such fine exceed an aggregate  
933 amount of \$10,000 for all nonwillful violations arising out of  
934 the same action. With respect to any knowing and willful  
935 violation of this section or the contract with the agency, the  
936 agency may impose a fine upon the entity in an amount not to  
937 exceed \$20,000 for each such violation. In no event shall such  
938 fine exceed an aggregate amount of \$100,000 for all knowing and  
939 willful violations arising out of the same action.

940 ~~(22) A health maintenance organization or a person or~~  
941 ~~entity exempt from chapter 641 that is under contract with the~~  
942 ~~agency for the provision of health care services to Medicaid~~  
943 ~~recipients may not use or distribute marketing materials used to~~  
944 ~~solicit Medicaid recipients, unless such materials have been~~  
945 ~~approved by the agency. The provisions of this subsection do not~~  
946 ~~apply to general advertising and marketing materials used by a~~  
947 ~~health maintenance organization to solicit both non-Medicaid~~  
948 ~~subscribers and Medicaid recipients. This subsection expires~~  
949 ~~October 1, 2014.~~

950 ~~(23) Upon approval by the agency, health maintenance~~  
951 ~~organizations and persons or entities exempt from chapter 641~~  
952 ~~that are under contract with the agency for the provision of~~  
953 ~~health care services to Medicaid recipients may be permitted~~  
954 ~~within the capitation rate to provide additional health benefits~~  
955 ~~that the agency has found are of high quality, are practicably~~  
956 ~~available, provide reasonable value to the recipient, and are~~  
957 ~~provided at no additional cost to the state. This subsection~~

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958 ~~expires October 1, 2014.~~

959 ~~(24) The agency shall utilize the statewide health~~  
960 ~~maintenance organization complaint hotline for the purpose of~~  
961 ~~investigating and resolving Medicaid and prepaid health plan~~  
962 ~~complaints, maintaining a record of complaints and confirmed~~  
963 ~~problems, and receiving disenrollment requests made by~~  
964 ~~recipients. This subsection expires October 1, 2014.~~

965 ~~(25) The agency shall require the publication of the health~~  
966 ~~maintenance organization's and the prepaid health plan's~~  
967 ~~consumer services telephone numbers and the "800" telephone~~  
968 ~~number of the statewide health maintenance organization~~  
969 ~~complaint hotline on each Medicaid identification card issued by~~  
970 ~~a health maintenance organization or prepaid health plan~~  
971 ~~contracting with the agency to serve Medicaid recipients and on~~  
972 ~~each subscriber handbook issued to a Medicaid recipient. This~~  
973 ~~subsection expires October 1, 2014.~~

974 ~~(7) (26)~~ The agency shall establish a health care quality  
975 improvement system for those entities contracting with the  
976 agency pursuant to this section, incorporating all the standards  
977 and guidelines developed by the Centers for Medicare and  
978 Medicaid Services Bureau of the Health Care Financing  
979 Administration as a part of the quality assurance reform  
980 initiative. The system shall include, but need not be limited  
981 to, the following:

982 (a) Guidelines for internal quality assurance programs,  
983 including standards for:

- 984 1. Written quality assurance program descriptions.  
985 2. Responsibilities of the governing body for monitoring,  
986 evaluating, and making improvements to care.

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- 987           3. An active quality assurance committee.
- 988           4. Quality assurance program supervision.
- 989           5. Requiring the program to have adequate resources to
- 990 effectively carry out its specified activities.
- 991           6. Provider participation in the quality assurance program.
- 992           7. Delegation of quality assurance program activities.
- 993           8. Credentialing and recredentialing.
- 994           9. Enrollee rights and responsibilities.
- 995           10. Availability and accessibility to services and care.
- 996           11. Ambulatory care facilities.
- 997           12. Accessibility and availability of medical records, as
- 998 well as proper recordkeeping and process for record review.
- 999           13. Utilization review.
- 1000           14. A continuity of care system.
- 1001           15. Quality assurance program documentation.
- 1002           16. Coordination of quality assurance activity with other
- 1003 management activity.
- 1004           17. Delivering care to pregnant women and infants; to
- 1005 elderly and disabled recipients, especially those who are at
- 1006 risk of institutional placement; to persons with developmental
- 1007 disabilities; and to adults who have chronic, high-cost medical
- 1008 conditions.
- 1009           (b) Guidelines which require the entities to conduct
- 1010 quality-of-care studies which:
- 1011           1. Target specific conditions and specific health service
- 1012 delivery issues for focused monitoring and evaluation.
- 1013           2. Use clinical care standards or practice guidelines to
- 1014 objectively evaluate the care the entity delivers or fails to
- 1015 deliver for the targeted clinical conditions and health services

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1016 delivery issues.

1017 3. Use quality indicators derived from the clinical care  
1018 standards or practice guidelines to screen and monitor care and  
1019 services delivered.

1020 (c) Guidelines for external quality review of each  
1021 contractor which require: focused studies of patterns of care;  
1022 individual care review in specific situations; and followup  
1023 activities on previous pattern-of-care study findings and  
1024 individual-care-review findings. In designing the external  
1025 quality review function and determining how it is to operate as  
1026 part of the state's overall quality improvement system, the  
1027 agency shall construct its external quality review organization  
1028 and entity contracts to address each of the following:

1029 1. Delineating the role of the external quality review  
1030 organization.

1031 2. Length of the external quality review organization  
1032 contract with the state.

1033 3. Participation of the contracting entities in designing  
1034 external quality review organization review activities.

1035 4. Potential variation in the type of clinical conditions  
1036 and health services delivery issues to be studied at each plan.

1037 5. Determining the number of focused pattern-of-care  
1038 studies to be conducted for each plan.

1039 6. Methods for implementing focused studies.

1040 7. Individual care review.

1041 8. Followup activities.

1042  
1043 This subsection expires October 1, 2016.

1044 ~~(27) In order to ensure that children receive health care~~

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1045 ~~services for which an entity has already been compensated, an~~  
1046 ~~entity contracting with the agency pursuant to this section~~  
1047 ~~shall achieve an annual Early and Periodic Screening, Diagnosis,~~  
1048 ~~and Treatment (EPSDT) Service screening rate of at least 60~~  
1049 ~~percent for those recipients continuously enrolled for at least~~  
1050 ~~8 months. The agency shall develop a method by which the EPSDT~~  
1051 ~~screening rate shall be calculated. For any entity which does~~  
1052 ~~not achieve the annual 60 percent rate, the entity must submit a~~  
1053 ~~corrective action plan for the agency's approval. If the entity~~  
1054 ~~does not meet the standard established in the corrective action~~  
1055 ~~plan during the specified timeframe, the agency is authorized to~~  
1056 ~~impose appropriate contract sanctions. At least annually, the~~  
1057 ~~agency shall publicly release the EPSDT Services screening rates~~  
1058 ~~of each entity it has contracted with on a prepaid basis to~~  
1059 ~~serve Medicaid recipients. This subsection expires October 1,~~  
1060 ~~2014.~~

1061 ~~(28) The agency shall perform enrollments and~~  
1062 ~~disenrollments for Medicaid recipients who are eligible for~~  
1063 ~~MediPass or managed care plans. Notwithstanding the prohibition~~  
1064 ~~contained in paragraph (20) (f), managed care plans may perform~~  
1065 ~~preenrollments of Medicaid recipients under the supervision of~~  
1066 ~~the agency or its agents. For the purposes of this section, the~~  
1067 ~~term "preenrollment" means the provision of marketing and~~  
1068 ~~educational materials to a Medicaid recipient and assistance in~~  
1069 ~~completing the application forms, but does not include actual~~  
1070 ~~enrollment into a managed care plan. An application for~~  
1071 ~~enrollment may not be deemed complete until the agency or its~~  
1072 ~~agent verifies that the recipient made an informed, voluntary~~  
1073 ~~choice. The agency, in cooperation with the Department of~~

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1074 ~~Children and Families, may test new marketing initiatives to~~  
1075 ~~inform Medicaid recipients about their managed care options at~~  
1076 ~~selected sites. The agency may contract with a third party to~~  
1077 ~~perform managed care plan and MediPass enrollment and~~  
1078 ~~disenrollment services for Medicaid recipients and may adopt~~  
1079 ~~rules to administer such services. The agency may adjust the~~  
1080 ~~capitation rate only to cover the costs of a third-party~~  
1081 ~~enrollment and disenrollment contract, and for agency~~  
1082 ~~supervision and management of the managed care plan enrollment~~  
1083 ~~and disenrollment contract. This subsection expires October 1,~~  
1084 ~~2014.~~

1085 ~~(29) Any lists of providers made available to Medicaid~~  
1086 ~~recipients, MediPass enrollees, or managed care plan enrollees~~  
1087 ~~shall be arranged alphabetically showing the provider's name and~~  
1088 ~~specialty and, separately, by specialty in alphabetical order.~~  
1089 ~~This subsection expires October 1, 2014.~~

1090 ~~(30) The agency shall establish an enhanced managed care~~  
1091 ~~quality assurance oversight function, to include at least the~~  
1092 ~~following components:~~

1093 ~~(a) At least quarterly analysis and followup, including~~  
1094 ~~sanctions as appropriate, of managed care participant~~  
1095 ~~utilization of services.~~

1096 ~~(b) At least quarterly analysis and followup, including~~  
1097 ~~sanctions as appropriate, of quality findings of the Medicaid~~  
1098 ~~peer review organization and other external quality assurance~~  
1099 ~~programs.~~

1100 ~~(c) At least quarterly analysis and followup, including~~  
1101 ~~sanctions as appropriate, of the fiscal viability of managed~~  
1102 ~~care plans.~~

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1103 ~~(d) At least quarterly analysis and followup, including~~  
1104 ~~sanctions as appropriate, of managed care participant~~  
1105 ~~satisfaction and disenrollment surveys.~~

1106 ~~(e) The agency shall conduct regular and ongoing Medicaid~~  
1107 ~~recipient satisfaction surveys.~~

1108  
1109 ~~The analyses and followup activities conducted by the agency~~  
1110 ~~under its enhanced managed care quality assurance oversight~~  
1111 ~~function shall not duplicate the activities of accreditation~~  
1112 ~~reviewers for entities regulated under part III of chapter 641,~~  
1113 ~~but may include a review of the finding of such reviewers. This~~  
1114 ~~subsection expires October 1, 2014.~~

1115 ~~(31) Each managed care plan that is under contract with the~~  
1116 ~~agency to provide health care services to Medicaid recipients~~  
1117 ~~shall annually conduct a background check with the Department of~~  
1118 ~~Law Enforcement of all persons with ownership interest of 5~~  
1119 ~~percent or more or executive management responsibility for the~~  
1120 ~~managed care plan and shall submit to the agency information~~  
1121 ~~concerning any such person who has been found guilty of,~~  
1122 ~~regardless of adjudication, or has entered a plea of nolo~~  
1123 ~~contendere or guilty to, any of the offenses listed in s.~~  
1124 ~~435.04. This subsection expires October 1, 2014.~~

1125 ~~(32) The agency shall, by rule, develop a process whereby a~~  
1126 ~~Medicaid managed care plan enrollee who wishes to enter hospice~~  
1127 ~~care may be disenrolled from the managed care plan within 24~~  
1128 ~~hours after contacting the agency regarding such request. The~~  
1129 ~~agency rule shall include a methodology for the agency to recoup~~  
1130 ~~managed care plan payments on a pro rata basis if payment has~~  
1131 ~~been made for the enrollment month when disenrollment occurs.~~

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1132 ~~This subsection expires October 1, 2014.~~

1133 ~~(33) The agency and entities that contract with the agency~~  
1134 ~~to provide health care services to Medicaid recipients under~~  
1135 ~~this section or ss. 409.91211 and 409.9122 must comply with the~~  
1136 ~~provisions of s. 641.513 in providing emergency services and~~  
1137 ~~care to Medicaid recipients and MediPass recipients. Where~~  
1138 ~~feasible, safe, and cost-effective, the agency shall encourage~~  
1139 ~~hospitals, emergency medical services providers, and other~~  
1140 ~~public and private health care providers to work together in~~  
1141 ~~their local communities to enter into agreements or arrangements~~  
1142 ~~to ensure access to alternatives to emergency services and care~~  
1143 ~~for those Medicaid recipients who need nonemergent care. The~~  
1144 ~~agency shall coordinate with hospitals, emergency medical~~  
1145 ~~services providers, private health plans, capitated managed care~~  
1146 ~~networks as established in s. 409.91211, and other public and~~  
1147 ~~private health care providers to implement the provisions of ss.~~  
1148 ~~395.1041(7), 409.91255(3)(g), 627.6405, and 641.31097 to develop~~  
1149 ~~and implement emergency department diversion programs for~~  
1150 ~~Medicaid recipients. This subsection expires October 1, 2014.~~

1151 ~~(34) All entities providing health care services to~~  
1152 ~~Medicaid recipients shall make available, and encourage all~~  
1153 ~~pregnant women and mothers with infants to receive, and provide~~  
1154 ~~documentation in the medical records to reflect, the following:~~

1155 ~~(a) Healthy Start prenatal or infant screening.~~

1156 ~~(b) Healthy Start care coordination, when screening or~~  
1157 ~~other factors indicate need.~~

1158 ~~(c) Healthy Start enhanced services in accordance with the~~  
1159 ~~prenatal or infant screening results.~~

1160 ~~(d) Immunizations in accordance with recommendations of the~~



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1161 ~~Advisory Committee on Immunization Practices of the United~~  
1162 ~~States Public Health Service and the American Academy of~~  
1163 ~~Pediatrics, as appropriate.~~

1164 ~~(e) Counseling and services for family planning to all~~  
1165 ~~women and their partners.~~

1166 ~~(f) A scheduled postpartum visit for the purpose of~~  
1167 ~~voluntary family planning, to include discussion of all methods~~  
1168 ~~of contraception, as appropriate.~~

1169 ~~(g) Referral to the Special Supplemental Nutrition Program~~  
1170 ~~for Women, Infants, and Children (WIC).~~

1171

1172 ~~This subsection expires October 1, 2014.~~

1173 ~~(35) Any entity that provides Medicaid prepaid health plan~~  
1174 ~~services shall ensure the appropriate coordination of health~~  
1175 ~~care services with an assisted living facility in cases where a~~  
1176 ~~Medicaid recipient is both a member of the entity's prepaid~~  
1177 ~~health plan and a resident of the assisted living facility. If~~  
1178 ~~the entity is at risk for Medicaid targeted case management and~~  
1179 ~~behavioral health services, the entity shall inform the assisted~~  
1180 ~~living facility of the procedures to follow should an emergent~~  
1181 ~~condition arise. This subsection expires October 1, 2014.~~

1182 ~~(36) The agency shall enter into agreements with not-for-~~  
1183 ~~profit organizations based in this state for the purpose of~~  
1184 ~~providing vision screening. This subsection expires October 1,~~  
1185 ~~2014.~~

1186 (8)~~(37)~~(a) The agency shall implement a Medicaid  
1187 prescribed-drug spending-control program that includes the  
1188 following components:

1189 1. A Medicaid preferred drug list, which shall be a listing

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1190 of cost-effective therapeutic options recommended by the  
1191 Medicaid Pharmacy and Therapeutics Committee established  
1192 pursuant to s. 409.91195 and adopted by the agency for each  
1193 therapeutic class on the preferred drug list. At the discretion  
1194 of the committee, and when feasible, the preferred drug list  
1195 should include at least two products in a therapeutic class. The  
1196 agency may post the preferred drug list and updates to the list  
1197 on an Internet website without following the rulemaking  
1198 procedures of chapter 120. Antiretroviral agents are excluded  
1199 from the preferred drug list. The agency shall also limit the  
1200 amount of a prescribed drug dispensed to no more than a 34-day  
1201 supply unless the drug products' smallest marketed package is  
1202 greater than a 34-day supply, or the drug is determined by the  
1203 agency to be a maintenance drug in which case a 100-day maximum  
1204 supply may be authorized. The agency may seek any federal  
1205 waivers necessary to implement these cost-control programs and  
1206 to continue participation in the federal Medicaid rebate  
1207 program, or alternatively to negotiate state-only manufacturer  
1208 rebates. The agency may adopt rules to administer this  
1209 subparagraph. The agency shall continue to provide unlimited  
1210 contraceptive drugs and items. The agency must establish  
1211 procedures to ensure that:

1212 a. There is a response to a request for prior consultation  
1213 by telephone or other telecommunication device within 24 hours  
1214 after receipt of a request for prior consultation; and

1215 b. A 72-hour supply of the drug prescribed is provided in  
1216 an emergency or when the agency does not provide a response  
1217 within 24 hours as required by sub-subparagraph a.

1218 2. Reimbursement to pharmacies for Medicaid prescribed

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1219 drugs shall be set at the lowest of: the average wholesale price  
1220 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)  
1221 plus 1.5 percent, the federal upper limit (FUL), the state  
1222 maximum allowable cost (SMAC), or the usual and customary (UAC)  
1223 charge billed by the provider.

1224 3. The agency shall develop and implement a process for  
1225 managing the drug therapies of Medicaid recipients who are using  
1226 significant numbers of prescribed drugs each month. The  
1227 management process may include, but is not limited to,  
1228 comprehensive, physician-directed medical-record reviews, claims  
1229 analyses, and case evaluations to determine the medical  
1230 necessity and appropriateness of a patient's treatment plan and  
1231 drug therapies. The agency may contract with a private  
1232 organization to provide drug-program-management services. The  
1233 Medicaid drug benefit management program shall include  
1234 initiatives to manage drug therapies for HIV/AIDS patients,  
1235 patients using 20 or more unique prescriptions in a 180-day  
1236 period, and the top 1,000 patients in annual spending. The  
1237 agency shall enroll any Medicaid recipient in the drug benefit  
1238 management program if he or she meets the specifications of this  
1239 provision and is not enrolled in a Medicaid health maintenance  
1240 organization.

1241 4. The agency may limit the size of its pharmacy network  
1242 based on need, competitive bidding, price negotiations,  
1243 credentialing, or similar criteria. The agency shall give  
1244 special consideration to rural areas in determining the size and  
1245 location of pharmacies included in the Medicaid pharmacy  
1246 network. A pharmacy credentialing process may include criteria  
1247 such as a pharmacy's full-service status, location, size,

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1248 patient educational programs, patient consultation, disease  
1249 management services, and other characteristics. The agency may  
1250 impose a moratorium on Medicaid pharmacy enrollment if it is  
1251 determined that it has a sufficient number of Medicaid-  
1252 participating providers. The agency must allow dispensing  
1253 practitioners to participate as a part of the Medicaid pharmacy  
1254 network regardless of the practitioner's proximity to any other  
1255 entity that is dispensing prescription drugs under the Medicaid  
1256 program. A dispensing practitioner must meet all credentialing  
1257 requirements applicable to his or her practice, as determined by  
1258 the agency.

1259         5. The agency shall develop and implement a program that  
1260 requires Medicaid practitioners who prescribe drugs to use a  
1261 counterfeit-proof prescription pad for Medicaid prescriptions.  
1262 The agency shall require the use of standardized counterfeit-  
1263 proof prescription pads by Medicaid-participating prescribers or  
1264 prescribers who write prescriptions for Medicaid recipients. The  
1265 agency may implement the program in targeted geographic areas or  
1266 statewide.

1267         6. The agency may enter into arrangements that require  
1268 manufacturers of generic drugs prescribed to Medicaid recipients  
1269 to provide rebates of at least 15.1 percent of the average  
1270 manufacturer price for the manufacturer's generic products.  
1271 These arrangements shall require that if a generic-drug  
1272 manufacturer pays federal rebates for Medicaid-reimbursed drugs  
1273 at a level below 15.1 percent, the manufacturer must provide a  
1274 supplemental rebate to the state in an amount necessary to  
1275 achieve a 15.1-percent rebate level.

1276         7. The agency may establish a preferred drug list as

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1277 described in this subsection, and, pursuant to the establishment  
1278 of such preferred drug list, negotiate supplemental rebates from  
1279 manufacturers that are in addition to those required by Title  
1280 XIX of the Social Security Act and at no less than 14 percent of  
1281 the average manufacturer price as defined in 42 U.S.C. s. 1936  
1282 on the last day of a quarter unless the federal or supplemental  
1283 rebate, or both, equals or exceeds 29 percent. There is no upper  
1284 limit on the supplemental rebates the agency may negotiate. The  
1285 agency may determine that specific products, brand-name or  
1286 generic, are competitive at lower rebate percentages. Agreement  
1287 to pay the minimum supplemental rebate percentage guarantees a  
1288 manufacturer that the Medicaid Pharmaceutical and Therapeutics  
1289 Committee will consider a product for inclusion on the preferred  
1290 drug list. However, a pharmaceutical manufacturer is not  
1291 guaranteed placement on the preferred drug list by simply paying  
1292 the minimum supplemental rebate. Agency decisions will be made  
1293 on the clinical efficacy of a drug and recommendations of the  
1294 Medicaid Pharmaceutical and Therapeutics Committee, as well as  
1295 the price of competing products minus federal and state rebates.  
1296 The agency may contract with an outside agency or contractor to  
1297 conduct negotiations for supplemental rebates. For the purposes  
1298 of this section, the term "supplemental rebates" means cash  
1299 rebates. Value-added programs as a substitution for supplemental  
1300 rebates are prohibited. The agency may seek any federal waivers  
1301 to implement this initiative.

1302 8. The agency shall expand home delivery of pharmacy  
1303 products. The agency may amend the state plan and issue a  
1304 procurement, as necessary, in order to implement this program.  
1305 The procurements must include agreements with a pharmacy or

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1306 pharmacies located in the state to provide mail order delivery  
1307 services at no cost to the recipients who elect to receive home  
1308 delivery of pharmacy products. The procurement must focus on  
1309 serving recipients with chronic diseases for which pharmacy  
1310 expenditures represent a significant portion of Medicaid  
1311 pharmacy expenditures or which impact a significant portion of  
1312 the Medicaid population. The agency may seek and implement any  
1313 federal waivers necessary to implement this subparagraph.

1314 9. The agency shall limit to one dose per month any drug  
1315 prescribed to treat erectile dysfunction.

1316 10.a. The agency may implement a Medicaid behavioral drug  
1317 management system. The agency may contract with a vendor that  
1318 has experience in operating behavioral drug management systems  
1319 to implement this program. The agency may seek federal waivers  
1320 to implement this program.

1321 b. The agency, in conjunction with the Department of  
1322 Children and Families, may implement the Medicaid behavioral  
1323 drug management system that is designed to improve the quality  
1324 of care and behavioral health prescribing practices based on  
1325 best practice guidelines, improve patient adherence to  
1326 medication plans, reduce clinical risk, and lower prescribed  
1327 drug costs and the rate of inappropriate spending on Medicaid  
1328 behavioral drugs. The program may include the following  
1329 elements:

1330 (I) Provide for the development and adoption of best  
1331 practice guidelines for behavioral health-related drugs such as  
1332 antipsychotics, antidepressants, and medications for treating  
1333 bipolar disorders and other behavioral conditions; translate  
1334 them into practice; review behavioral health prescribers and

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1335 compare their prescribing patterns to a number of indicators  
1336 that are based on national standards; and determine deviations  
1337 from best practice guidelines.

1338 (II) Implement processes for providing feedback to and  
1339 educating prescribers using best practice educational materials  
1340 and peer-to-peer consultation.

1341 (III) Assess Medicaid beneficiaries who are outliers in  
1342 their use of behavioral health drugs with regard to the numbers  
1343 and types of drugs taken, drug dosages, combination drug  
1344 therapies, and other indicators of improper use of behavioral  
1345 health drugs.

1346 (IV) Alert prescribers to patients who fail to refill  
1347 prescriptions in a timely fashion, are prescribed multiple same-  
1348 class behavioral health drugs, and may have other potential  
1349 medication problems.

1350 (V) Track spending trends for behavioral health drugs and  
1351 deviation from best practice guidelines.

1352 (VI) Use educational and technological approaches to  
1353 promote best practices, educate consumers, and train prescribers  
1354 in the use of practice guidelines.

1355 (VII) Disseminate electronic and published materials.

1356 (VIII) Hold statewide and regional conferences.

1357 (IX) Implement a disease management program with a model  
1358 quality-based medication component for severely mentally ill  
1359 individuals and emotionally disturbed children who are high  
1360 users of care.

1361 11. The agency shall implement a Medicaid prescription drug  
1362 management system.

1363 a. The agency may contract with a vendor that has

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1364 experience in operating prescription drug management systems in  
1365 order to implement this system. Any management system that is  
1366 implemented in accordance with this subparagraph must rely on  
1367 cooperation between physicians and pharmacists to determine  
1368 appropriate practice patterns and clinical guidelines to improve  
1369 the prescribing, dispensing, and use of drugs in the Medicaid  
1370 program. The agency may seek federal waivers to implement this  
1371 program.

1372 b. The drug management system must be designed to improve  
1373 the quality of care and prescribing practices based on best  
1374 practice guidelines, improve patient adherence to medication  
1375 plans, reduce clinical risk, and lower prescribed drug costs and  
1376 the rate of inappropriate spending on Medicaid prescription  
1377 drugs. The program must:

1378 (I) Provide for the adoption of best practice guidelines  
1379 for the prescribing and use of drugs in the Medicaid program,  
1380 including translating best practice guidelines into practice;  
1381 reviewing prescriber patterns and comparing them to indicators  
1382 that are based on national standards and practice patterns of  
1383 clinical peers in their community, statewide, and nationally;  
1384 and determine deviations from best practice guidelines.

1385 (II) Implement processes for providing feedback to and  
1386 educating prescribers using best practice educational materials  
1387 and peer-to-peer consultation.

1388 (III) Assess Medicaid recipients who are outliers in their  
1389 use of a single or multiple prescription drugs with regard to  
1390 the numbers and types of drugs taken, drug dosages, combination  
1391 drug therapies, and other indicators of improper use of  
1392 prescription drugs.



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1393 (IV) Alert prescribers to recipients who fail to refill  
1394 prescriptions in a timely fashion, are prescribed multiple drugs  
1395 that may be redundant or contraindicated, or may have other  
1396 potential medication problems.

1397 12. The agency may contract for drug rebate administration,  
1398 including, but not limited to, calculating rebate amounts,  
1399 invoicing manufacturers, negotiating disputes with  
1400 manufacturers, and maintaining a database of rebate collections.

1401 13. The agency may specify the preferred daily dosing form  
1402 or strength for the purpose of promoting best practices with  
1403 regard to the prescribing of certain drugs as specified in the  
1404 General Appropriations Act and ensuring cost-effective  
1405 prescribing practices.

1406 14. The agency may require prior authorization for  
1407 Medicaid-covered prescribed drugs. The agency may prior-  
1408 authorize the use of a product:

- 1409 a. For an indication not approved in labeling;  
1410 b. To comply with certain clinical guidelines; or  
1411 c. If the product has the potential for overuse, misuse, or  
1412 abuse.

1413  
1414 The agency may require the prescribing professional to provide  
1415 information about the rationale and supporting medical evidence  
1416 for the use of a drug. The agency shall post prior  
1417 authorization, step-edit criteria and protocol, and updates to  
1418 the list of drugs that are subject to prior authorization on the  
1419 agency's Internet website within 21 days after the prior  
1420 authorization and step-edit criteria and protocol and updates  
1421 are approved by the agency. For purposes of this subparagraph,

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1422 the term "step-edit" means an automatic electronic review of  
1423 certain medications subject to prior authorization.

1424 15. The agency, in conjunction with the Pharmaceutical and  
1425 Therapeutics Committee, may require age-related prior  
1426 authorizations for certain prescribed drugs. The agency may  
1427 preauthorize the use of a drug for a recipient who may not meet  
1428 the age requirement or may exceed the length of therapy for use  
1429 of this product as recommended by the manufacturer and approved  
1430 by the Food and Drug Administration. Prior authorization may  
1431 require the prescribing professional to provide information  
1432 about the rationale and supporting medical evidence for the use  
1433 of a drug.

1434 16. The agency shall implement a step-therapy prior  
1435 authorization approval process for medications excluded from the  
1436 preferred drug list. Medications listed on the preferred drug  
1437 list must be used within the previous 12 months before the  
1438 alternative medications that are not listed. The step-therapy  
1439 prior authorization may require the prescriber to use the  
1440 medications of a similar drug class or for a similar medical  
1441 indication unless contraindicated in the Food and Drug  
1442 Administration labeling. The trial period between the specified  
1443 steps may vary according to the medical indication. The step-  
1444 therapy approval process shall be developed in accordance with  
1445 the committee as stated in s. 409.91195(7) and (8). A drug  
1446 product may be approved without meeting the step-therapy prior  
1447 authorization criteria if the prescribing physician provides the  
1448 agency with additional written medical or clinical documentation  
1449 that the product is medically necessary because:

1450 a. There is not a drug on the preferred drug list to treat

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1451 the disease or medical condition which is an acceptable clinical  
1452 alternative;

1453 b. The alternatives have been ineffective in the treatment  
1454 of the beneficiary's disease; or

1455 c. Based on historic evidence and known characteristics of  
1456 the patient and the drug, the drug is likely to be ineffective,  
1457 or the number of doses have been ineffective.

1458

1459 The agency shall work with the physician to determine the best  
1460 alternative for the patient. The agency may adopt rules waiving  
1461 the requirements for written clinical documentation for specific  
1462 drugs in limited clinical situations.

1463 17. The agency shall implement a return and reuse program  
1464 for drugs dispensed by pharmacies to institutional recipients,  
1465 which includes payment of a \$5 restocking fee for the  
1466 implementation and operation of the program. The return and  
1467 reuse program shall be implemented electronically and in a  
1468 manner that promotes efficiency. The program must permit a  
1469 pharmacy to exclude drugs from the program if it is not  
1470 practical or cost-effective for the drug to be included and must  
1471 provide for the return to inventory of drugs that cannot be  
1472 credited or returned in a cost-effective manner. The agency  
1473 shall determine if the program has reduced the amount of  
1474 Medicaid prescription drugs which are destroyed on an annual  
1475 basis and if there are additional ways to ensure more  
1476 prescription drugs are not destroyed which could safely be  
1477 reused.

1478 (b) The agency shall implement this subsection to the  
1479 extent that funds are appropriated to administer the Medicaid

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1480 prescribed-drug spending-control program. The agency may  
1481 contract all or any part of this program to private  
1482 organizations.

1483 (c) The agency shall submit quarterly reports to the  
1484 Governor, the President of the Senate, and the Speaker of the  
1485 House of Representatives which must include, but need not be  
1486 limited to, the progress made in implementing this subsection  
1487 and its effect on Medicaid prescribed-drug expenditures.

1488 (9)~~(38)~~ Notwithstanding the provisions of chapter 287, the  
1489 agency may, at its discretion, renew a contract or contracts for  
1490 fiscal intermediary services one or more times for such periods  
1491 as the agency may decide; however, all such renewals may not  
1492 combine to exceed a total period longer than the term of the  
1493 original contract.

1494 ~~(39) The agency shall establish a demonstration project in~~  
1495 ~~Miami-Dade County of a long-term care facility and a psychiatric~~  
1496 ~~facility licensed pursuant to chapter 395 to improve access to~~  
1497 ~~health care for a predominantly minority, medically underserved,~~  
1498 ~~and medically complex population and to evaluate alternatives to~~  
1499 ~~nursing home care and general acute care for such population.~~  
1500 ~~Such project is to be located in a health care condominium and~~  
1501 ~~collocated with licensed facilities providing a continuum of~~  
1502 ~~care. These projects are not subject to the provisions of s.~~  
1503 ~~408.036 or s. 408.039. This subsection expires October 1, 2013.~~

1504 ~~(40) The agency shall develop and implement a utilization~~  
1505 ~~management program for Medicaid-eligible recipients for the~~  
1506 ~~management of occupational, physical, respiratory, and speech~~  
1507 ~~therapies. The agency shall establish a utilization program that~~  
1508 ~~may require prior authorization in order to ensure medically~~

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1509 ~~necessary and cost-effective treatments. The program shall be~~  
1510 ~~operated in accordance with a federally approved waiver program~~  
1511 ~~or state plan amendment. The agency may seek a federal waiver or~~  
1512 ~~state plan amendment to implement this program. The agency may~~  
1513 ~~also competitively procure these services from an outside vendor~~  
1514 ~~on a regional or statewide basis. This subsection expires~~  
1515 ~~October 1, 2014.~~

1516 ~~(41) (a) The agency shall contract on a prepaid or fixed-sum~~  
1517 ~~basis with appropriately licensed prepaid dental health plans to~~  
1518 ~~provide dental services. This paragraph expires October 1, 2014.~~

1519 ~~(b) Notwithstanding paragraph (a) and for the 2012-2013~~  
1520 ~~fiscal year only, the agency is authorized to provide a Medicaid~~  
1521 ~~prepaid dental health program in Miami-Dade County. For all~~  
1522 ~~other counties, the agency may not limit dental services to~~  
1523 ~~prepaid plans and must allow qualified dental providers to~~  
1524 ~~provide dental services under Medicaid on a fee-for-service~~  
1525 ~~reimbursement methodology. The agency may seek any necessary~~  
1526 ~~revisions or amendments to the state plan or federal waivers in~~  
1527 ~~order to implement this paragraph. The agency shall terminate~~  
1528 ~~existing contracts as needed to implement this paragraph. This~~  
1529 ~~paragraph expires July 1, 2013.~~

1530 ~~(42) The Agency for Health Care Administration shall ensure~~  
1531 ~~that any Medicaid managed care plan as defined in s.~~  
1532 ~~409.9122(2)(f), whether paid on a capitated basis or a shared~~  
1533 ~~savings basis, is cost-effective. For purposes of this~~  
1534 ~~subsection, the term "cost-effective" means that a network's~~  
1535 ~~per-member, per-month costs to the state, including, but not~~  
1536 ~~limited to, fee-for-service costs, administrative costs, and~~  
1537 ~~case-management fees, if any, must be no greater than the~~

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1538 ~~state's costs associated with contracts for Medicaid services~~  
1539 ~~established under subsection (3), which may be adjusted for~~  
1540 ~~health status. The agency shall conduct actuarially sound~~  
1541 ~~adjustments for health status in order to ensure such cost-~~  
1542 ~~effectiveness and shall annually publish the results on its~~  
1543 ~~Internet website. Contracts established pursuant to this~~  
1544 ~~subsection which are not cost-effective may not be renewed. This~~  
1545 ~~subsection expires October 1, 2014.~~

1546 ~~(43) Subject to the availability of funds, the agency shall~~  
1547 ~~mandate a recipient's participation in a provider lock-in~~  
1548 ~~program, when appropriate, if a recipient is found by the agency~~  
1549 ~~to have used Medicaid goods or services at a frequency or amount~~  
1550 ~~not medically necessary, limiting the receipt of goods or~~  
1551 ~~services to medically necessary providers after the 21-day~~  
1552 ~~appeal process has ended, for a period of not less than 1 year.~~  
1553 ~~The lock-in programs shall include, but are not limited to,~~  
1554 ~~pharmacies, medical doctors, and infusion clinics. The~~  
1555 ~~limitation does not apply to emergency services and care~~  
1556 ~~provided to the recipient in a hospital emergency department.~~  
1557 ~~The agency shall seek any federal waivers necessary to implement~~  
1558 ~~this subsection. The agency shall adopt any rules necessary to~~  
1559 ~~comply with or administer this subsection. This subsection~~  
1560 ~~expires October 1, 2014.~~

1561 ~~(10)(44)~~ The agency shall seek a federal waiver for  
1562 permission to terminate the eligibility of a Medicaid recipient  
1563 who has been found to have committed fraud, through judicial or  
1564 administrative determination, two times in a period of 5 years.

1565 (11)~~(45)~~(a) A provider is not entitled to enrollment in the  
1566 Medicaid provider network. The agency may implement a Medicaid

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1567 fee-for-service provider network controls, including, but not  
1568 limited to, competitive procurement and provider credentialing.  
1569 If a credentialing process is used, the agency may limit its  
1570 provider network based upon the following considerations:  
1571 beneficiary access to care, provider availability, provider  
1572 quality standards and quality assurance processes, cultural  
1573 competency, demographic characteristics of beneficiaries,  
1574 practice standards, service wait times, provider turnover,  
1575 provider licensure and accreditation history, program integrity  
1576 history, peer review, Medicaid policy and billing compliance  
1577 records, clinical and medical record audit findings, and such  
1578 other areas that are considered necessary by the agency to  
1579 ensure the integrity of the program.

1580 (b) The agency shall limit its network of durable medical  
1581 equipment and medical supply providers. For dates of service  
1582 after January 1, 2009, the agency shall limit payment for  
1583 durable medical equipment and supplies to providers that meet  
1584 all the requirements of this paragraph.

1585 1. Providers must be accredited by a Centers for Medicare  
1586 and Medicaid Services deemed accreditation organization for  
1587 suppliers of durable medical equipment, prosthetics, orthotics,  
1588 and supplies. The provider must maintain accreditation and is  
1589 subject to unannounced reviews by the accrediting organization.

1590 2. Providers must provide the services or supplies directly  
1591 to the Medicaid recipient or caregiver at the provider location  
1592 or recipient's residence or send the supplies directly to the  
1593 recipient's residence with receipt of mailed delivery.

1594 Subcontracting or consignment of the service or supply to a  
1595 third party is prohibited.

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1596 3. Notwithstanding subparagraph 2., a durable medical  
1597 equipment provider may store nebulizers at a physician's office  
1598 for the purpose of having the physician's staff issue the  
1599 equipment if it meets all of the following conditions:

1600 a. The physician must document the medical necessity and  
1601 need to prevent further deterioration of the patient's  
1602 respiratory status by the timely delivery of the nebulizer in  
1603 the physician's office.

1604 b. The durable medical equipment provider must have written  
1605 documentation of the competency and training by a Florida-  
1606 licensed registered respiratory therapist of any durable medical  
1607 equipment staff who participate in the training of physician  
1608 office staff for the use of nebulizers, including cleaning,  
1609 warranty, and special needs of patients.

1610 c. The physician's office must have documented the training  
1611 and competency of any staff member who initiates the delivery of  
1612 nebulizers to patients. The durable medical equipment provider  
1613 must maintain copies of all physician office training.

1614 d. The physician's office must maintain inventory records  
1615 of stored nebulizers, including documentation of the durable  
1616 medical equipment provider source.

1617 e. A physician contracted with a Medicaid durable medical  
1618 equipment provider may not have a financial relationship with  
1619 that provider or receive any financial gain from the delivery of  
1620 nebulizers to patients.

1621 4. Providers must have a physical business location and a  
1622 functional landline business phone. The location must be within  
1623 the state or not more than 50 miles from the Florida state line.  
1624 The agency may make exceptions for providers of durable medical



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1625 equipment or supplies not otherwise available from other  
1626 enrolled providers located within the state.

1627       5. Physical business locations must be clearly identified  
1628 as a business that furnishes durable medical equipment or  
1629 medical supplies by signage that can be read from 20 feet away.  
1630 The location must be readily accessible to the public during  
1631 normal, posted business hours and must operate at least 5 hours  
1632 per day and at least 5 days per week, with the exception of  
1633 scheduled and posted holidays. The location may not be located  
1634 within or at the same numbered street address as another  
1635 enrolled Medicaid durable medical equipment or medical supply  
1636 provider or as an enrolled Medicaid pharmacy that is also  
1637 enrolled as a durable medical equipment provider. A licensed  
1638 orthotist or prosthetist that provides only orthotic or  
1639 prosthetic devices as a Medicaid durable medical equipment  
1640 provider is exempt from this paragraph.

1641       6. Providers must maintain a stock of durable medical  
1642 equipment and medical supplies on site that is readily available  
1643 to meet the needs of the durable medical equipment business  
1644 location's customers.

1645       7. Providers must provide a surety bond of \$50,000 for each  
1646 provider location, up to a maximum of 5 bonds statewide or an  
1647 aggregate bond of \$250,000 statewide, as identified by Federal  
1648 Employer Identification Number. Providers who post a statewide  
1649 or an aggregate bond must identify all of their locations in any  
1650 Medicaid durable medical equipment and medical supply provider  
1651 enrollment application or bond renewal. Each provider location's  
1652 surety bond must be renewed annually and the provider must  
1653 submit proof of renewal even if the original bond is a

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1654 continuous bond. A licensed orthotist or prosthetist that  
1655 provides only orthotic or prosthetic devices as a Medicaid  
1656 durable medical equipment provider is exempt from the provisions  
1657 in this paragraph.

1658 8. Providers must obtain a level 2 background screening, in  
1659 accordance with chapter 435 and s. 408.809, for each provider  
1660 employee in direct contact with or providing direct services to  
1661 recipients of durable medical equipment and medical supplies in  
1662 their homes. This requirement includes, but is not limited to,  
1663 repair and service technicians, fitters, and delivery staff. The  
1664 provider shall pay for the cost of the background screening.

1665 9. The following providers are exempt from subparagraphs 1.  
1666 and 7.:

1667 a. Durable medical equipment providers owned and operated  
1668 by a government entity.

1669 b. Durable medical equipment providers that are operating  
1670 within a pharmacy that is currently enrolled as a Medicaid  
1671 pharmacy provider.

1672 c. Active, Medicaid-enrolled orthopedic physician groups,  
1673 primarily owned by physicians, which provide only orthotic and  
1674 prosthetic devices.

1675 ~~(46) The agency shall contract with established minority~~  
1676 ~~physician networks that provide services to historically~~  
1677 ~~underserved minority patients. The networks must provide cost-~~  
1678 ~~effective Medicaid services, comply with the requirements to be~~  
1679 ~~a MediPass provider, and provide their primary care physicians~~  
1680 ~~with access to data and other management tools necessary to~~  
1681 ~~assist them in ensuring the appropriate use of services,~~  
1682 ~~including inpatient hospital services and pharmaceuticals.~~

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1683           ~~(a) The agency shall provide for the development and~~  
1684 ~~expansion of minority physician networks in each service area to~~  
1685 ~~provide services to Medicaid recipients who are eligible to~~  
1686 ~~participate under federal law and rules.~~

1687           ~~(b) The agency shall reimburse each minority physician~~  
1688 ~~network as a fee-for-service provider, including the case~~  
1689 ~~management fee for primary care, if any, or as a capitated rate~~  
1690 ~~provider for Medicaid services. Any savings shall be shared with~~  
1691 ~~the minority physician networks pursuant to the contract.~~

1692           ~~(c) For purposes of this subsection, the term "cost-~~  
1693 ~~effective" means that a network's per-member, per-month costs to~~  
1694 ~~the state, including, but not limited to, fee-for-service costs,~~  
1695 ~~administrative costs, and case-management fees, if any, must be~~  
1696 ~~no greater than the state's costs associated with contracts for~~  
1697 ~~Medicaid services established under subsection (3), which shall~~  
1698 ~~be actuarially adjusted for case mix, model, and service area.~~  
1699 ~~The agency shall conduct actuarially sound audits adjusted for~~  
1700 ~~case mix and model in order to ensure such cost-effectiveness~~  
1701 ~~and shall annually publish the audit results on its Internet~~  
1702 ~~website. Contracts established pursuant to this subsection which~~  
1703 ~~are not cost-effective may not be renewed.~~

1704           ~~(d) The agency may apply for any federal waivers needed to~~  
1705 ~~implement this subsection.~~

1706  
1707 ~~This subsection expires October 1, 2014.~~

1708           (12)~~(47)~~ To the extent permitted by federal law and as  
1709 allowed under s. 409.906, the agency shall provide reimbursement  
1710 for emergency mental health care services for Medicaid  
1711 recipients in crisis stabilization facilities licensed under s.

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1712 394.875 as long as those services are less expensive than the  
1713 same services provided in a hospital setting.

1714 (13)~~(48)~~ The agency shall work with the Agency for Persons  
1715 with Disabilities to develop a home and community-based waiver  
1716 to serve children and adults who are diagnosed with familial  
1717 dysautonomia or Riley-Day syndrome caused by a mutation of the  
1718 IKBKAP gene on chromosome 9. The agency shall seek federal  
1719 waiver approval and implement the approved waiver subject to the  
1720 availability of funds and any limitations provided in the  
1721 General Appropriations Act. The agency may adopt rules to  
1722 implement this waiver program.

1723 (14)~~(49)~~ The agency shall implement a program of all-  
1724 inclusive care for children. The program of all-inclusive care  
1725 for children shall be established to provide in-home hospice-  
1726 like support services to children diagnosed with a life-  
1727 threatening illness and enrolled in the Children's Medical  
1728 Services network to reduce hospitalizations as appropriate. The  
1729 agency, in consultation with the Department of Health, may  
1730 implement the program of all-inclusive care for children after  
1731 obtaining approval from the Centers for Medicare and Medicaid  
1732 Services.

1733 (15)~~(50)~~ Before seeking an amendment to the state plan for  
1734 purposes of implementing programs authorized by the Deficit  
1735 Reduction Act of 2005, the agency shall notify the Legislature.

1736 (16)~~(51)~~ The agency may not pay for psychotropic medication  
1737 prescribed for a child in the Medicaid program without the  
1738 express and informed consent of the child's parent or legal  
1739 guardian. The physician shall document the consent in the  
1740 child's medical record and provide the pharmacy with a signed

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1741 attestation of this documentation with the prescription. The  
1742 express and informed consent or court authorization for a  
1743 prescription of psychotropic medication for a child in the  
1744 custody of the Department of Children and Families shall be  
1745 obtained pursuant to s. 39.407.

1746 Reviser's note.—Amended to conform to the repeals of numerous  
1747 subunits pursuant to their own terms, effective at various  
1748 dates in 2013 and 2014. Material in existing s.  
1749 409.912(4)(d)4. referencing s. 409.91211 was deleted to  
1750 conform to the repeal of that section effective October 1,  
1751 2014, by s. 20, ch. 2011-135, Laws of Florida, and  
1752 confirmation of that repeal by this reviser's bill. The  
1753 reference in subsection (26), redesignated here as  
1754 subsection (7), to the Medicaid Bureau of the Health Care  
1755 Financing Administration was redesignated as the Centers  
1756 for Medicare and Medicaid Services to conform to the  
1757 renaming of the federal agency.

1758 Section 15. Section 409.91211, Florida Statutes, is  
1759 repealed.

1760 Reviser's note.—The cited section, which relates to the Medicaid  
1761 managed care pilot program, was repealed by s. 20, ch.  
1762 2011-135, Laws of Florida, effective October 1, 2014. Since  
1763 the section was not repealed by a "current session" of the  
1764 Legislature, it may be omitted from the 2015 Florida  
1765 Statutes only through a reviser's bill duly enacted by the  
1766 Legislature. See s. 11.242(5)(b) and (i).

1767 Section 16. Section 409.9122, Florida Statutes, is amended  
1768 to read:  
1769 409.9122 Mandatory Medicaid managed care enrollment;

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1770 programs and procedures.—

1771 ~~(1) It is the intent of the Legislature that the MediPass~~  
1772 ~~program be cost-effective, provide quality health care, and~~  
1773 ~~improve access to health services, and that the program be~~  
1774 ~~statewide. This subsection expires October 1, 2014.~~

1775 ~~(2)(a) The agency shall enroll in a managed care plan or~~  
1776 ~~MediPass all Medicaid recipients, except those Medicaid~~  
1777 ~~recipients who are: in an institution; enrolled in the Medicaid~~  
1778 ~~medically needy program; or eligible for both Medicaid and~~  
1779 ~~Medicare. Upon enrollment, individuals will be able to change~~  
1780 ~~their managed care option during the 90-day opt out period~~  
1781 ~~required by federal Medicaid regulations. The agency is~~  
1782 ~~authorized to seek the necessary Medicaid state plan amendment~~  
1783 ~~to implement this policy. However, to the extent permitted by~~  
1784 ~~federal law, the agency may enroll in a managed care plan or~~  
1785 ~~MediPass a Medicaid recipient who is exempt from mandatory~~  
1786 ~~managed care enrollment, provided that:~~

1787 ~~1. The recipient's decision to enroll in a managed care~~  
1788 ~~plan or MediPass is voluntary;~~

1789 ~~2. If the recipient chooses to enroll in a managed care~~  
1790 ~~plan, the agency has determined that the managed care plan~~  
1791 ~~provides specific programs and services which address the~~  
1792 ~~special health needs of the recipient; and~~

1793 ~~3. The agency receives any necessary waivers from the~~  
1794 ~~federal Centers for Medicare and Medicaid Services.~~

1795  
1796 ~~School districts participating in the certified school match~~  
1797 ~~program pursuant to ss. 409.908(21) and 1011.70 shall be~~  
1798 ~~reimbursed by Medicaid, subject to the limitations of s.~~

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1799 ~~1011.70(1), for a Medicaid-eligible child participating in the~~  
1800 ~~services as authorized in s. 1011.70, as provided for in s.~~  
1801 ~~409.9071, regardless of whether the child is enrolled in~~  
1802 ~~MediPass or a managed care plan. Managed care plans shall make a~~  
1803 ~~good faith effort to execute agreements with school districts~~  
1804 ~~regarding the coordinated provision of services authorized under~~  
1805 ~~s. 1011.70. County health departments delivering school-based~~  
1806 ~~services pursuant to ss. 381.0056 and 381.0057 shall be~~  
1807 ~~reimbursed by Medicaid for the federal share for a Medicaid-~~  
1808 ~~eligible child who receives Medicaid-covered services in a~~  
1809 ~~school setting, regardless of whether the child is enrolled in~~  
1810 ~~MediPass or a managed care plan. Managed care plans shall make a~~  
1811 ~~good faith effort to execute agreements with county health~~  
1812 ~~departments regarding the coordinated provision of services to a~~  
1813 ~~Medicaid-eligible child. To ensure continuity of care for~~  
1814 ~~Medicaid patients, the agency, the Department of Health, and the~~  
1815 ~~Department of Education shall develop procedures for ensuring~~  
1816 ~~that a student's managed care plan or MediPass provider receives~~  
1817 ~~information relating to services provided in accordance with ss.~~  
1818 ~~381.0056, 381.0057, 409.9071, and 1011.70.~~

1819 ~~(b) A Medicaid recipient may not be enrolled in or assigned~~  
1820 ~~to a managed care plan or MediPass unless the managed care plan~~  
1821 ~~or MediPass has complied with the quality of care standards~~  
1822 ~~specified in paragraphs (4) (a) and (b), respectively.~~

1823 ~~(c) Medicaid recipients shall have a choice of managed care~~  
1824 ~~plans or MediPass. The Agency for Health Care Administration,~~  
1825 ~~the Department of Health, the Department of Children and~~  
1826 ~~Families, and the Department of Elderly Affairs shall cooperate~~  
1827 ~~to ensure that each Medicaid recipient receives clear and easily~~

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1828 ~~understandable information that meets the following~~  
1829 ~~requirements:~~

1830 ~~1. Explains the concept of managed care, including~~  
1831 ~~MediPass.~~

1832 ~~2. Provides information on the comparative performance of~~  
1833 ~~managed care plans and MediPass in the areas of quality,~~  
1834 ~~credentialing, preventive health programs, network size and~~  
1835 ~~availability, and patient satisfaction.~~

1836 ~~3. Explains where additional information on each managed~~  
1837 ~~care plan and MediPass in the recipient's area can be obtained.~~

1838 ~~4. Explains that recipients have the right to choose their~~  
1839 ~~managed care coverage at the time they first enroll in Medicaid~~  
1840 ~~and again at regular intervals set by the agency. However, if a~~  
1841 ~~recipient does not choose a managed care plan or MediPass, the~~  
1842 ~~agency will assign the recipient to a managed care plan or~~  
1843 ~~MediPass according to the criteria specified in this section.~~

1844 ~~5. Explains the recipient's right to complain, file a~~  
1845 ~~grievance, or change managed care plans or MediPass providers if~~  
1846 ~~the recipient is not satisfied with the managed care plan or~~  
1847 ~~MediPass.~~

1848 ~~(d) The agency shall develop a mechanism for providing~~  
1849 ~~information to Medicaid recipients for the purpose of making a~~  
1850 ~~managed care plan or MediPass selection. Examples of such~~  
1851 ~~mechanisms may include, but not be limited to, interactive~~  
1852 ~~information systems, mailings, and mass marketing materials.~~  
1853 ~~Managed care plans and MediPass providers are prohibited from~~  
1854 ~~providing inducements to Medicaid recipients to select their~~  
1855 ~~plans or from prejudicing Medicaid recipients against other~~  
1856 ~~managed care plans or MediPass providers.~~



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1857       ~~(e) Medicaid recipients who are already enrolled in a~~  
1858 ~~managed care plan or MediPass shall be offered the opportunity~~  
1859 ~~to change managed care plans or MediPass providers on a~~  
1860 ~~staggered basis, as defined by the agency. All Medicaid~~  
1861 ~~recipients shall have 30 days in which to make a choice of~~  
1862 ~~managed care plans or MediPass providers. Those Medicaid~~  
1863 ~~recipients who do not make a choice shall be assigned in~~  
1864 ~~accordance with paragraph (f). To facilitate continuity of care,~~  
1865 ~~for a Medicaid recipient who is also a recipient of Supplemental~~  
1866 ~~Security Income (SSI), prior to assigning the SSI recipient to a~~  
1867 ~~managed care plan or MediPass, the agency shall determine~~  
1868 ~~whether the SSI recipient has an ongoing relationship with a~~  
1869 ~~MediPass provider or managed care plan, and if so, the agency~~  
1870 ~~shall assign the SSI recipient to that MediPass provider or~~  
1871 ~~managed care plan. Those SSI recipients who do not have such a~~  
1872 ~~provider relationship shall be assigned to a managed care plan~~  
1873 ~~or MediPass provider in accordance with paragraph (f).~~

1874       ~~(f) If a Medicaid recipient does not choose a managed care~~  
1875 ~~plan or MediPass provider, the agency shall assign the Medicaid~~  
1876 ~~recipient to a managed care plan or MediPass provider. Medicaid~~  
1877 ~~recipients eligible for managed care plan enrollment who are~~  
1878 ~~subject to mandatory assignment but who fail to make a choice~~  
1879 ~~shall be assigned to managed care plans until an enrollment of~~  
1880 ~~35 percent in MediPass and 65 percent in managed care plans, of~~  
1881 ~~all those eligible to choose managed care, is achieved. Once~~  
1882 ~~this enrollment is achieved, the assignments shall be divided in~~  
1883 ~~order to maintain an enrollment in MediPass and managed care~~  
1884 ~~plans which is in a 35 percent and 65 percent proportion,~~  
1885 ~~respectively. Thereafter, assignment of Medicaid recipients who~~

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1886 ~~fail to make a choice shall be based proportionally on the~~  
1887 ~~preferences of recipients who have made a choice in the previous~~  
1888 ~~period. Such proportions shall be revised at least quarterly to~~  
1889 ~~reflect an update of the preferences of Medicaid recipients. The~~  
1890 ~~agency shall disproportionately assign Medicaid eligible~~  
1891 ~~recipients who are required to but have failed to make a choice~~  
1892 ~~of managed care plan or MediPass to the Children's Medical~~  
1893 ~~Services Network as defined in s. 391.021, exclusive provider~~  
1894 ~~organizations, provider service networks, minority physician~~  
1895 ~~networks, and pediatric emergency department diversion programs~~  
1896 ~~authorized by this chapter or the General Appropriations Act, in~~  
1897 ~~such manner as the agency deems appropriate, until the agency~~  
1898 ~~has determined that the networks and programs have sufficient~~  
1899 ~~numbers to be operated economically. For purposes of this~~  
1900 ~~paragraph, when referring to assignment, the term "managed care~~  
1901 ~~plans" includes health maintenance organizations, exclusive~~  
1902 ~~provider organizations, provider service networks, minority~~  
1903 ~~physician networks, Children's Medical Services Network, and~~  
1904 ~~pediatric emergency department diversion programs authorized by~~  
1905 ~~this chapter or the General Appropriations Act. When making~~  
1906 ~~assignments, the agency shall take into account the following~~  
1907 ~~criteria:~~

1908 ~~1. A managed care plan has sufficient network capacity to~~  
1909 ~~meet the need of members.~~

1910 ~~2. The managed care plan or MediPass has previously~~  
1911 ~~enrolled the recipient as a member, or one of the managed care~~  
1912 ~~plan's primary care providers or MediPass providers has~~  
1913 ~~previously provided health care to the recipient.~~

1914 ~~3. The agency has knowledge that the member has previously~~

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1915 ~~expressed a preference for a particular managed care plan or~~  
1916 ~~MediPass provider as indicated by Medicaid fee-for-service~~  
1917 ~~claims data, but has failed to make a choice.~~

1918 ~~4. The managed care plan's or MediPass primary care~~  
1919 ~~providers are geographically accessible to the recipient's~~  
1920 ~~residence.~~

1921 ~~(g) When more than one managed care plan or MediPass~~  
1922 ~~provider meets the criteria specified in paragraph (f), the~~  
1923 ~~agency shall make recipient assignments consecutively by family~~  
1924 ~~unit.~~

1925 ~~(h) The agency may not engage in practices that are~~  
1926 ~~designed to favor one managed care plan over another or that are~~  
1927 ~~designed to influence Medicaid recipients to enroll in MediPass~~  
1928 ~~rather than in a managed care plan or to enroll in a managed~~  
1929 ~~care plan rather than in MediPass. This subsection does not~~  
1930 ~~prohibit the agency from reporting on the performance of~~  
1931 ~~MediPass or any managed care plan, as measured by performance~~  
1932 ~~criteria developed by the agency.~~

1933 ~~(i) After a recipient has made his or her selection or has~~  
1934 ~~been enrolled in a managed care plan or MediPass, the recipient~~  
1935 ~~shall have 90 days to exercise the opportunity to voluntarily~~  
1936 ~~disenroll and select another managed care plan or MediPass.~~  
1937 ~~After 90 days, no further changes may be made except for good~~  
1938 ~~cause. Good cause includes, but is not limited to, poor quality~~  
1939 ~~of care, lack of access to necessary specialty services, an~~  
1940 ~~unreasonable delay or denial of service, or fraudulent~~  
1941 ~~enrollment. The agency shall develop criteria for good cause~~  
1942 ~~disenrollment for chronically ill and disabled populations who~~  
1943 ~~are assigned to managed care plans if more appropriate care is~~

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1944 ~~available through the MediPass program. The agency must make a~~  
1945 ~~determination as to whether cause exists. However, the agency~~  
1946 ~~may require a recipient to use the managed care plan's or~~  
1947 ~~MediPass grievance process prior to the agency's determination~~  
1948 ~~of cause, except in cases in which immediate risk of permanent~~  
1949 ~~damage to the recipient's health is alleged. The grievance~~  
1950 ~~process, when utilized, must be completed in time to permit the~~  
1951 ~~recipient to disenroll by the first day of the second month~~  
1952 ~~after the month the disenrollment request was made. If the~~  
1953 ~~managed care plan or MediPass, as a result of the grievance~~  
1954 ~~process, approves an enrollee's request to disenroll, the agency~~  
1955 ~~is not required to make a determination in the case. The agency~~  
1956 ~~must make a determination and take final action on a recipient's~~  
1957 ~~request so that disenrollment occurs no later than the first day~~  
1958 ~~of the second month after the month the request was made. If the~~  
1959 ~~agency fails to act within the specified timeframe, the~~  
1960 ~~recipient's request to disenroll is deemed to be approved as of~~  
1961 ~~the date agency action was required. Recipients who disagree~~  
1962 ~~with the agency's finding that cause does not exist for~~  
1963 ~~disenrollment shall be advised of their right to pursue a~~  
1964 ~~Medicaid fair hearing to dispute the agency's finding.~~

1965 ~~(j) The agency shall apply for a federal waiver from the~~  
1966 ~~Centers for Medicare and Medicaid Services to lock eligible~~  
1967 ~~Medicaid recipients into a managed care plan or MediPass for 12~~  
1968 ~~months after an open enrollment period. After 12 months'~~  
1969 ~~enrollment, a recipient may select another managed care plan or~~  
1970 ~~MediPass provider. However, nothing shall prevent a Medicaid~~  
1971 ~~recipient from changing primary care providers within the~~  
1972 ~~managed care plan or MediPass program during the 12-month~~

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1973 ~~period.~~

1974 ~~(k) When a Medicaid recipient does not choose a managed~~  
1975 ~~care plan or MediPass provider, the agency shall assign the~~  
1976 ~~Medicaid recipient to a managed care plan, except in those~~  
1977 ~~counties in which there are fewer than two managed care plans~~  
1978 ~~accepting Medicaid enrollees, in which case assignment shall be~~  
1979 ~~to a managed care plan or a MediPass provider. Medicaid~~  
1980 ~~recipients in counties with fewer than two managed care plans~~  
1981 ~~accepting Medicaid enrollees who are subject to mandatory~~  
1982 ~~assignment but who fail to make a choice shall be assigned to~~  
1983 ~~managed care plans until an enrollment of 35 percent in MediPass~~  
1984 ~~and 65 percent in managed care plans, of all those eligible to~~  
1985 ~~choose managed care, is achieved. Once that enrollment is~~  
1986 ~~achieved, the assignments shall be divided in order to maintain~~  
1987 ~~an enrollment in MediPass and managed care plans which is in a~~  
1988 ~~35 percent and 65 percent proportion, respectively. For purposes~~  
1989 ~~of this paragraph, when referring to assignment, the term~~  
1990 ~~"managed care plans" includes exclusive provider organizations,~~  
1991 ~~provider service networks, Children's Medical Services Network,~~  
1992 ~~minority physician networks, and pediatric emergency department~~  
1993 ~~diversion programs authorized by this chapter or the General~~  
1994 ~~Appropriations Act. When making assignments, the agency shall~~  
1995 ~~take into account the following criteria:~~

1996 ~~1. A managed care plan has sufficient network capacity to~~  
1997 ~~meet the need of members.~~

1998 ~~2. The managed care plan or MediPass has previously~~  
1999 ~~enrolled the recipient as a member, or one of the managed care~~  
2000 ~~plan's primary care providers or MediPass providers has~~  
2001 ~~previously provided health care to the recipient.~~

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2002           ~~3. The agency has knowledge that the member has previously~~  
2003 ~~expressed a preference for a particular managed care plan or~~  
2004 ~~MediPass provider as indicated by Medicaid fee-for-service~~  
2005 ~~claims data, but has failed to make a choice.~~

2006           ~~4. The managed care plan's or MediPass primary care~~  
2007 ~~providers are geographically accessible to the recipient's~~  
2008 ~~residence.~~

2009           ~~5. The agency has authority to make mandatory assignments~~  
2010 ~~based on quality of service and performance of managed care~~  
2011 ~~plans.~~

2012           ~~(1) Notwithstanding chapter 287, the agency may renew cost-~~  
2013 ~~effective contracts for choice counseling services once or more~~  
2014 ~~for such periods as the agency may decide. However, all such~~  
2015 ~~renewals may not combine to exceed a total period longer than~~  
2016 ~~the term of the original contract.~~

2017  
2018 ~~This subsection expires October 1, 2014.~~

2019           ~~(3)~~ Notwithstanding s. 409.961, if a Medicaid recipient is  
2020 diagnosed with HIV/AIDS, the agency shall assign the recipient  
2021 to a managed care plan that is a health maintenance organization  
2022 authorized under chapter 641, that is under contract with the  
2023 agency as an HIV/AIDS specialty plan as of January 1, 2013, and  
2024 that offers a delivery system through a university-based  
2025 teaching and research-oriented organization that specializes in  
2026 providing health care services and treatment for individuals  
2027 diagnosed with HIV/AIDS. This subsection applies to recipients  
2028 who are subject to mandatory managed care enrollment and have  
2029 failed to choose a managed care option.

2030           ~~(4) (a) The agency shall establish quality of care standards~~

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2031 ~~for managed care plans. These standards shall be based upon, but~~  
2032 ~~are not limited to:~~

2033 ~~1. Compliance with the accreditation requirements as~~  
2034 ~~provided in s. 641.512.~~

2035 ~~2. Compliance with Early and Periodic Screening, Diagnosis,~~  
2036 ~~and Treatment screening requirements.~~

2037 ~~3. The percentage of voluntary disenrollments.~~

2038 ~~4. Immunization rates.~~

2039 ~~5. Standards of the National Committee for Quality~~  
2040 ~~Assurance and other approved accrediting bodies.~~

2041 ~~6. Recommendations of other authoritative bodies.~~

2042 ~~7. Specific requirements of the Medicaid program, or~~  
2043 ~~standards designed to specifically assist the unique needs of~~  
2044 ~~Medicaid recipients.~~

2045 ~~8. Compliance with the health quality improvement system as~~  
2046 ~~established by the agency, which incorporates standards and~~  
2047 ~~guidelines developed by the Medicaid Bureau of the Health Care~~  
2048 ~~Financing Administration as part of the quality assurance reform~~  
2049 ~~initiative.~~

2050 ~~(b) For the MediPass program, the agency shall establish~~  
2051 ~~standards which are based upon, but are not limited to:~~

2052 ~~1. Quality of care standards which are comparable to those~~  
2053 ~~required of managed care plans.~~

2054 ~~2. Credentialing standards for MediPass providers.~~

2055 ~~3. Compliance with Early and Periodic Screening, Diagnosis,~~  
2056 ~~and Treatment screening requirements.~~

2057 ~~4. Immunization rates.~~

2058 ~~5. Specific requirements of the Medicaid program, or~~  
2059 ~~standards designed to specifically assist the unique needs of~~

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2060 ~~Medicaid recipients.~~

2061

2062 ~~This subsection expires October 1, 2014.~~

2063 ~~(5) (a) Each female recipient may select as her primary care~~  
2064 ~~provider an obstetrician/gynecologist who has agreed to~~  
2065 ~~participate as a MediPass primary care case manager.~~

2066 ~~(b) The agency shall establish a complaints and grievance~~  
2067 ~~process to assist Medicaid recipients enrolled in the MediPass~~  
2068 ~~program to resolve complaints and grievances. The agency shall~~  
2069 ~~investigate reports of quality-of-care grievances which remain~~  
2070 ~~unresolved to the satisfaction of the enrollee.~~

2071

2072 ~~This subsection expires October 1, 2014.~~

2073 ~~(6) (a) The agency shall work cooperatively with the Social~~  
2074 ~~Security Administration to identify beneficiaries who are~~  
2075 ~~jointly eligible for Medicare and Medicaid and shall develop~~  
2076 ~~cooperative programs to encourage these beneficiaries to enroll~~  
2077 ~~in a Medicare participating health maintenance organization or~~  
2078 ~~prepaid health plans.~~

2079 ~~(b) The agency shall work cooperatively with the Department~~  
2080 ~~of Elderly Affairs to assess the potential cost-effectiveness of~~  
2081 ~~providing MediPass to beneficiaries who are jointly eligible for~~  
2082 ~~Medicare and Medicaid on a voluntary choice basis. If the agency~~  
2083 ~~determines that enrollment of these beneficiaries in MediPass~~  
2084 ~~has the potential for being cost-effective for the state, the~~  
2085 ~~agency shall offer MediPass to these beneficiaries on a~~  
2086 ~~voluntary choice basis in the counties where MediPass operates.~~

2087

2088 ~~This subsection expires October 1, 2014.~~



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2089       ~~(7) MediPass enrolled recipients may receive up to 10~~  
2090 ~~visits of reimbursable services by participating Medicaid~~  
2091 ~~physicians licensed under chapter 460 and up to four visits of~~  
2092 ~~reimbursable services by participating Medicaid physicians~~  
2093 ~~licensed under chapter 461. Any further visits must be by prior~~  
2094 ~~authorization by the MediPass primary care provider. However,~~  
2095 ~~nothing in this subsection may be construed to increase the~~  
2096 ~~total number of visits or the total amount of dollars per year~~  
2097 ~~per person under current Medicaid rules, unless otherwise~~  
2098 ~~provided for in the General Appropriations Act. This subsection~~  
2099 ~~expires October 1, 2014.~~

2100       ~~(8) (a) The agency shall develop and implement a~~  
2101 ~~comprehensive plan to ensure that recipients are adequately~~  
2102 ~~informed of their choices and rights under all Medicaid managed~~  
2103 ~~care programs and that Medicaid managed care programs meet~~  
2104 ~~acceptable standards of quality in patient care, patient~~  
2105 ~~satisfaction, and financial solvency.~~

2106       ~~(b) The agency shall provide adequate means for informing~~  
2107 ~~patients of their choice and rights under a managed care plan at~~  
2108 ~~the time of eligibility determination.~~

2109       ~~(c) The agency shall require managed care plans and~~  
2110 ~~MediPass providers to demonstrate and document plans and~~  
2111 ~~activities, as defined by rule, including outreach and followup,~~  
2112 ~~undertaken to ensure that Medicaid recipients receive the health~~  
2113 ~~care service to which they are entitled.~~

2114  
2115 ~~This subsection expires October 1, 2014.~~

2116       ~~(9) The agency shall consult with Medicaid consumers and~~  
2117 ~~their representatives on an ongoing basis regarding measurements~~

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2118 ~~of patient satisfaction, procedures for resolving patient~~  
2119 ~~grievances, standards for ensuring quality of care, mechanisms~~  
2120 ~~for providing patient access to services, and policies affecting~~  
2121 ~~patient care. This subsection expires October 1, 2014.~~

2122 ~~(10) The agency may extend eligibility for Medicaid~~  
2123 ~~recipients enrolled in licensed and accredited health~~  
2124 ~~maintenance organizations for the duration of the enrollment~~  
2125 ~~period or for 6 months, whichever is earlier, provided the~~  
2126 ~~agency certifies that such an offer will not increase state~~  
2127 ~~expenditures. This subsection expires October 1, 2013.~~

2128 ~~(11) A managed care plan that has a Medicaid contract shall~~  
2129 ~~at least annually review each primary care physician's active~~  
2130 ~~patient load and shall ensure that additional Medicaid~~  
2131 ~~recipients are not assigned to physicians who have a total~~  
2132 ~~active patient load of more than 3,000 patients. As used in this~~  
2133 ~~subsection, the term "active patient" means a patient who is~~  
2134 ~~seen by the same primary care physician, or by a physician~~  
2135 ~~assistant or advanced registered nurse practitioner under the~~  
2136 ~~supervision of the primary care physician, at least three times~~  
2137 ~~within a calendar year. Each primary care physician shall~~  
2138 ~~annually certify to the managed care plan whether or not his or~~  
2139 ~~her patient load exceeds the limits established under this~~  
2140 ~~subsection and the managed care plan shall accept such~~  
2141 ~~certification on face value as compliance with this subsection.~~  
2142 ~~The agency shall accept the managed care plan's representations~~  
2143 ~~that it is in compliance with this subsection based on the~~  
2144 ~~certification of its primary care physicians, unless the agency~~  
2145 ~~has an objective indication that access to primary care is being~~  
2146 ~~compromised, such as receiving complaints or grievances relating~~

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2147 ~~to access to care. If the agency determines that an objective~~  
2148 ~~indication exists that access to primary care is being~~  
2149 ~~compromised, it may verify the patient load certifications~~  
2150 ~~submitted by the managed care plan's primary care physicians and~~  
2151 ~~that the managed care plan is not assigning Medicaid recipients~~  
2152 ~~to primary care physicians who have an active patient load of~~  
2153 ~~more than 3,000 patients. This subsection expires October 1,~~  
2154 ~~2014.~~

2155 ~~(12) Effective July 1, 2003, the agency shall adjust the~~  
2156 ~~enrollee assignment process of Medicaid managed prepaid health~~  
2157 ~~plans for those Medicaid managed prepaid plans operating in~~  
2158 ~~Miami Dade County which have executed a contract with the agency~~  
2159 ~~for a minimum of 8 consecutive years in order for the Medicaid~~  
2160 ~~managed prepaid plan to maintain a minimum enrollment level of~~  
2161 ~~15,000 members per month. When assigning enrollees pursuant to~~  
2162 ~~this subsection, the agency shall give priority to providers~~  
2163 ~~that initially qualified under this subsection until such~~  
2164 ~~providers reach and maintain an enrollment level of 15,000~~  
2165 ~~members per month. A prepaid health plan that has a statewide~~  
2166 ~~Medicaid enrollment of 25,000 or more members is not eligible~~  
2167 ~~for enrollee assignments under this subsection. This subsection~~  
2168 ~~expires October 1, 2014.~~

2169 ~~(2) (13)~~ (2) The agency shall include in its calculation of the  
2170 hospital inpatient component of a Medicaid health maintenance  
2171 organization's capitation rate any special payments, including,  
2172 but not limited to, upper payment limit or disproportionate  
2173 share hospital payments, made to qualifying hospitals through  
2174 the fee-for-service program. The agency may seek federal waiver  
2175 approval or state plan amendment as needed to implement this

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2176 adjustment.

2177 (3)~~(14)~~ The agency shall develop a process to enable any  
2178 recipient with access to employer-sponsored health care coverage  
2179 to opt out of all eligible plans in the Medicaid program and to  
2180 use Medicaid financial assistance to pay for the recipient's  
2181 share of cost in any such employer-sponsored coverage.

2182 Contingent on federal approval, the agency shall also enable  
2183 recipients with access to other insurance or related products  
2184 that provide access to health care services created pursuant to  
2185 state law, including any plan or product available pursuant to  
2186 the Florida Health Choices Program or any health exchange, to  
2187 opt out. The amount of financial assistance provided for each  
2188 recipient may not exceed the amount of the Medicaid premium that  
2189 would have been paid to a plan for that recipient.

2190 (4)~~(15)~~ The agency shall maintain and operate the Medicaid  
2191 Encounter Data System to collect, process, store, and report on  
2192 covered services provided to all Florida Medicaid recipients  
2193 enrolled in prepaid managed care plans.

2194 (a) Prepaid managed care plans shall submit encounter data  
2195 electronically in a format that complies with the Health  
2196 Insurance Portability and Accountability Act provisions for  
2197 electronic claims and in accordance with deadlines established  
2198 by the agency. Prepaid managed care plans must certify that the  
2199 data reported is accurate and complete.

2200 (b) The agency is responsible for validating the data  
2201 submitted by the plans. The agency shall develop methods and  
2202 protocols for ongoing analysis of the encounter data that  
2203 adjusts for differences in characteristics of prepaid plan  
2204 enrollees to allow comparison of service utilization among plans

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2205 and against expected levels of use. The analysis shall be used  
2206 to identify possible cases of systemic underutilization or  
2207 denials of claims and inappropriate service utilization such as  
2208 higher-than-expected emergency department encounters. The  
2209 analysis shall provide periodic feedback to the plans and enable  
2210 the agency to establish corrective action plans when necessary.  
2211 One of the focus areas for the analysis shall be the use of  
2212 prescription drugs.

2213 (5)~~(16)~~ The agency may establish a per-member, per-month  
2214 payment for Medicare Advantage Special Needs members that are  
2215 also eligible for Medicaid as a mechanism for meeting the  
2216 state's cost-sharing obligation. The agency may also develop a  
2217 per-member, per-month payment only for Medicaid-covered services  
2218 for which the state is responsible. The agency shall develop a  
2219 mechanism to ensure that such per-member, per-month payment  
2220 enhances the value to the state and enrolled members by limiting  
2221 cost sharing, enhances the scope of Medicare supplemental  
2222 benefits that are equal to or greater than Medicaid coverage for  
2223 select services, and improves care coordination.

2224 (6)~~(17)~~ The agency shall establish, and managed care plans  
2225 shall use, a uniform method of accounting for and reporting  
2226 medical and nonmedical costs.

2227 (a) Managed care plans shall submit financial data  
2228 electronically in a format that complies with the uniform  
2229 accounting procedures established by the agency. Managed care  
2230 plans must certify that the data reported is accurate and  
2231 complete.

2232 (b) The agency is responsible for validating the financial  
2233 data submitted by the plans. The agency shall develop methods

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2234 and protocols for ongoing analysis of data that adjusts for  
2235 differences in characteristics of plan enrollees to allow  
2236 comparison among plans and against expected levels of  
2237 expenditures. The analysis shall be used to identify possible  
2238 cases of overspending on administrative costs or underspending  
2239 on medical services.

2240 (7)~~(18)~~ The agency shall establish and maintain an  
2241 information system to make encounter data, financial data, and  
2242 other measures of plan performance available to the public and  
2243 any interested party.

2244 (a) Information submitted by the managed care plans shall  
2245 be available online as well as in other formats.

2246 (b) Periodic agency reports shall be published that include  
2247 summary as well as plan specific measures of financial  
2248 performance and service utilization.

2249 (c) Any release of the financial and encounter data  
2250 submitted by managed care plans shall ensure the confidentiality  
2251 of personal health information.

2252 (8)~~(19)~~ The agency may, on a case-by-case basis, exempt a  
2253 recipient from mandatory enrollment in a managed care plan when  
2254 the recipient has a unique, time-limited disease or condition-  
2255 related circumstance and managed care enrollment will interfere  
2256 with ongoing care because the recipient's provider does not  
2257 participate in the managed care plans available in the  
2258 recipient's area.

2259 ~~(20) The agency shall contract with a single provider  
2260 service network to function as a managing entity for the  
2261 MediPass program in all counties with fewer than two prepaid  
2262 plans. The contractor shall be responsible for implementing~~

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2263 ~~preauthorization procedures, case management programs, and~~  
2264 ~~utilization management initiatives in order to improve care~~  
2265 ~~coordination and patient outcomes while reducing costs. The~~  
2266 ~~contractor may earn an administrative fee if the fee is less~~  
2267 ~~than any savings as determined by the reconciliation process~~  
2268 ~~under s. 409.912(4)(d)1. This subsection expires October 1,~~  
2269 ~~2014, or upon full implementation of the managed medical~~  
2270 ~~assistance program, whichever is sooner.~~

2271 ~~(21) Subject to federal approval, the agency shall contract~~  
2272 ~~with a single provider service network to function as a third-~~  
2273 ~~party administrator and managing entity for the Medically Needy~~  
2274 ~~program in all counties. The contractor shall provide care~~  
2275 ~~coordination and utilization management in order to achieve more~~  
2276 ~~cost-effective services for Medically Needy enrollees. To~~  
2277 ~~facilitate the care management functions of the provider service~~  
2278 ~~network, enrollment in the network shall be for a continuous 6-~~  
2279 ~~month period or until the end of the contract between the~~  
2280 ~~provider service network and the agency, whichever is sooner.~~  
2281 ~~Beginning the second month after the determination of~~  
2282 ~~eligibility, the contractor may collect a monthly premium from~~  
2283 ~~each Medically Needy recipient provided the premium does not~~  
2284 ~~exceed the enrollee's share of cost as determined by the~~  
2285 ~~Department of Children and Families. The contractor must provide~~  
2286 ~~a 90-day grace period before disenrolling a Medically Needy~~  
2287 ~~recipient for failure to pay premiums. The contractor may earn~~  
2288 ~~an administrative fee, if the fee is less than any savings~~  
2289 ~~determined by the reconciliation process pursuant to s.~~  
2290 ~~409.912(4)(d)1. Premium revenue collected from the recipients~~  
2291 ~~shall be deducted from the contractor's earned savings. This~~

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2292 subsection expires October 1, 2014, or upon full implementation  
2293 of the managed medical assistance program, whichever is sooner.

2294 (9)~~(22)~~ If required as a condition of a waiver, the agency  
2295 may calculate a medical loss ratio for managed care plans. The  
2296 calculation shall utilize uniform financial data collected from  
2297 all plans and shall be computed for each plan on a statewide  
2298 basis. The method for calculating the medical loss ratio shall  
2299 meet the following criteria:

2300 (a) Except as provided in paragraphs (b) and (c),  
2301 expenditures shall be classified in a manner consistent with 45  
2302 C.F.R. part 158.

2303 (b) Funds provided by plans to graduate medical education  
2304 institutions to underwrite the costs of residency positions  
2305 shall be classified as medical expenditures, provided the  
2306 funding is sufficient to sustain the positions for the number of  
2307 years necessary to complete the residency requirements and the  
2308 residency positions funded by the plans are active providers of  
2309 care to Medicaid and uninsured patients.

2310 (c) Prior to final determination of the medical loss ratio  
2311 for any period, a plan may contribute to a designated state  
2312 trust fund for the purpose of supporting Medicaid and indigent  
2313 care and have the contribution counted as a medical expenditure  
2314 for the period.

2315 Reviser's note.—Amended to conform to the repeals of numerous  
2316 subunits pursuant to their own terms, effective at various  
2317 dates in 2013 and 2014.

2318 Section 17. Subsection (15) of section 430.04, Florida  
2319 Statutes, is repealed.

2320 Reviser's note.—The cited subsection, which relates to



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2321 authorization of the Department of Elderly Affairs to  
2322 administer all Medicaid waivers and programs relating to  
2323 elders and their appropriations, expired pursuant to its  
2324 own terms, effective October 1, 2014.

2325 Section 18. Subsections (10), (11), and (12) of section  
2326 430.502, Florida Statutes, are repealed.

2327 Reviser's note.—The cited subsections relate to seeking of a  
2328 federal waiver to implement a Medicaid home and community-  
2329 based waiver targeted to persons with Alzheimer's disease  
2330 to test the effectiveness of Alzheimer's specific  
2331 interventions to delay or to avoid institutional placement.  
2332 Subsection (12) provides that authority to continue the  
2333 waiver program is automatically eliminated at the close of  
2334 the 2010 Regular Session of the Legislature unless further  
2335 action is taken to continue it before such time.

2336 Section 19. Subsection (5) of section 443.131, Florida  
2337 Statutes, is repealed.

2338 Reviser's note.—The cited subsection, which relates to an  
2339 additional rate for interest on federal advances received  
2340 by the Unemployment Compensation Trust Fund, expired  
2341 pursuant to its own terms, effective July 1, 2014.

2342 Section 20. Subsection (1) of section 576.061, Florida  
2343 Statutes, is amended to read:

2344 576.061 Plant nutrient investigational allowances,  
2345 deficiencies, and penalties.—

2346 (1) A commercial fertilizer is deemed deficient if the  
2347 analysis of any nutrient is below the guarantee by an amount  
2348 exceeding the investigational allowances. The department shall  
2349 adopt rules, which shall take effect on July 1, 2014, that

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2350 establish the investigational allowances used to determine  
 2351 whether a fertilizer is deficient in plant food.

2352 ~~(a) Effective July 1, 2014, this paragraph and paragraphs~~  
 2353 ~~(b) (f) are repealed. Until July 1, 2014, investigational~~  
 2354 ~~allowances shall be set as provided in paragraphs (b) (f).~~

2355 ~~(b) Primary plant nutrients; investigational allowances.~~

2356

	Total	Available	
Guaranteed	Nitrogen	Phosphate	Potash
Percent	Percent	Percent	Percent

2357

2358

~~04 or less 0.49 0.67 0.41~~

2359

~~05 0.51 0.67 0.43~~

2360

~~06 0.52 0.67 0.47~~

2361

~~07 0.54 0.68 0.53~~

2362

~~08 0.55 0.68 0.60~~

2363

~~09 0.57 0.68 0.65~~

2364

~~10 0.58 0.69 0.70~~

2365

~~12 0.61 0.69 0.79~~

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2367	14	<del>0.63</del>	<del>0.70</del>	<del>0.87</del>
2368	16	<del>0.67</del>	<del>0.70</del>	<del>0.94</del>
2369	18	<del>0.70</del>	<del>0.71</del>	<del>1.01</del>
2370	20	<del>0.73</del>	<del>0.72</del>	<del>1.08</del>
2371	22	<del>0.75</del>	<del>0.72</del>	<del>1.15</del>
2372	24	<del>0.78</del>	<del>0.73</del>	<del>1.21</del>
2373	26	<del>0.81</del>	<del>0.73</del>	<del>1.27</del>
2374	28	<del>0.83</del>	<del>0.74</del>	<del>1.33</del>
2375	30	<del>0.86</del>	<del>0.75</del>	<del>1.39</del>
2376	<del>32 or more</del>	<del>0.88</del>	<del>0.76</del>	<del>1.44</del>

2378 ~~For guarantees not listed, calculate the appropriate value by~~  
 2379 ~~interpolation.~~

2380 ~~(c) Nitrogen investigational allowances.~~

2381 Nitrogen Investigational Allowances  
 2382 Breakdown Percent

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2383

Nitrate

nitrogen

~~0.40~~

2384

~~Ammoniacal~~

nitrogen

~~0.40~~

2385

~~Water soluble~~

nitrogen

~~or urea~~

nitrogen

~~0.40~~

2386

~~Water insoluble~~

nitrogen

~~0.30~~

2387

2388

2389

2390

~~In no case may the investigational allowance exceed 50 percent~~

2391

~~of the amount guaranteed.~~

2392

~~(d) Secondary and micro plant nutrients, total or soluble.~~

2393

~~Element~~

~~Investigational Allowances Percent~~

2394

2395

~~Calcium~~

~~0.2 unit + 5 percent of guarantee~~

2396

~~Magnesium~~

~~0.2 unit + 5 percent of guarantee~~

2397

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Sulfur

~~(free and  
combined)~~

~~0.2 unit + 5 percent of guarantee~~

2398

Boron

~~0.003 unit + 15 percent of guarantee~~

2399

Cobalt

~~0.0001 unit + 30 percent of guarantee~~

2400

Chlorine

~~0.005 unit + 10 percent of guarantee~~

2401

Copper

~~0.005 unit + 10 percent of guarantee~~

2402

Iron

~~0.005 unit + 10 percent of guarantee~~

2403

Manganese

~~0.005 unit + 10 percent of guarantee~~

2404

Molybdenum

~~0.0001 unit + 30 percent of guarantee~~

2405

Sodium

~~0.005 unit + 10 percent of guarantee~~

2406

Zinc

~~0.005 unit + 10 percent of guarantee~~

2407

2408

2409

~~The maximum allowance for secondary and minor elements when~~

~~calculated in accordance with this section is 1 unit (1~~

~~percent). In no case, however, may the investigational allowance~~

~~exceed 50 percent of the amount guaranteed.~~

~~(c) *Liming materials and gypsum.*~~

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Range	<del>Investigational Allowances</del>
Percent	Percent
<del>0-10</del>	<del>0.30</del>
<del>Over 10-</del>	
<del>25</del>	<del>0.40</del>
<del>Over 25</del>	<del>0.50</del>

~~(f) Pesticides in fertilizer mixtures.—An investigational allowance of 25 percent of the guarantee shall be allowed on all pesticides when added to custom blend fertilizers.~~

Reviser's note.—The cited paragraphs, which relate to investigational allowances for fertilizer, were repealed pursuant to their own terms, effective July 1, 2014.

Section 21. Section 624.351, Florida Statutes, is repealed.

Reviser's note.—The cited section, which relates to the Medicaid and Public Assistance Fraud Strike Force, was repealed pursuant to its own terms, effective June 30, 2014.

Section 22. Section 624.352, Florida Statutes, is repealed.

Reviser's note.—The cited section, which relates to interagency agreements to detect and deter Medicaid and public assistance fraud, was repealed pursuant to its own terms, effective June 30, 2014.

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2437           Section 23. Subsection (7) of section 626.2815, Florida  
 2438 Statutes, is repealed.

2439 Reviser's note.—The cited subsection, which relates to a  
 2440 requirement that persons holding a license to solicit or  
 2441 sell life insurance must complete a minimum of 3 hours in  
 2442 continuing education on the subject of suitability in  
 2443 annuity and life insurance transactions, was deleted from  
 2444 s. 626.2815 by s. 11, ch. 2012-209, Laws of Florida,  
 2445 effective October 1, 2014. Since the subsection was not  
 2446 repealed by a "current session" of the Legislature, it may  
 2447 be omitted from the 2015 Florida Statutes only through a  
 2448 reviser's bill duly enacted by the Legislature. See s.  
 2449 11.242(5) (b) and (i).

2450           Section 24. Paragraph (b) of subsection (4) of section  
 2451 828.27, Florida Statutes, is amended to read:

2452           828.27 Local animal control or cruelty ordinances;  
 2453 penalty.—

2454           (4)

2455           (b)~~1~~. The governing body of a county or municipality may  
 2456 impose and collect a surcharge of up to \$5 upon each civil  
 2457 penalty imposed for violation of an ordinance relating to animal  
 2458 control or cruelty. The proceeds from such surcharges shall be  
 2459 used to pay the costs of training for animal control officers.

2460           ~~2. In addition to the uses set forth in subparagraph 1., a~~  
 2461 ~~county, as defined in s. 125.011, may use the proceeds specified~~  
 2462 ~~in that subparagraph and any carryover or fund balance from such~~  
 2463 ~~proceeds for animal shelter operating expenses. This~~  
 2464 ~~subparagraph expires July 1, 2014.~~

2465 Reviser's note.—Amended to delete subparagraph (4) (b) 2., which

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2466 expired pursuant to its own terms, effective July 1, 2014.

2467 Section 25. Paragraph (e) of subsection (9) of section  
2468 1002.32, Florida Statutes, is amended to read:

2469 1002.32 Developmental research (laboratory) schools.—

2470 (9) FUNDING.—Funding for a lab school, including a charter  
2471 lab school, shall be provided as follows:

2472 (e)~~1~~. Each lab school shall receive funds for capital  
2473 improvement purposes in an amount determined as follows:

2474 multiply the maximum allowable nonvoted discretionary millage  
2475 for capital improvements pursuant to s. 1011.71(2) by 96 percent  
2476 of the current year's taxable value for school purposes for the  
2477 district in which each lab school is located; divide the result  
2478 by the total full-time equivalent membership of the district;  
2479 and multiply the result by the full-time equivalent membership  
2480 of the lab school. The amount obtained shall be discretionary  
2481 capital improvement funds and shall be appropriated from state  
2482 funds in the General Appropriations Act to the Lab School  
2483 Educational Facility Trust Fund.

2484 ~~2. Notwithstanding the provisions of subparagraph 1., for~~  
2485 ~~the 2013-2014 fiscal year, funds appropriated for capital~~  
2486 ~~improvement purposes shall be divided between lab schools based~~  
2487 ~~on full-time equivalent student membership. This subparagraph~~  
2488 ~~expires July 1, 2014.~~

2489 Reviser's note.—Amended to delete subparagraph (9)(e)2., which  
2490 expired pursuant to its own terms, effective July 1, 2014.

2491 Section 26. Subsection (4) of section 409.91195, Florida  
2492 Statutes, is amended to read:

2493 409.91195 Medicaid Pharmaceutical and Therapeutics

2494 Committee.—There is created a Medicaid Pharmaceutical and



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2495 Therapeutics Committee within the agency for the purpose of  
2496 developing a Medicaid preferred drug list.

2497 (4) Upon recommendation of the committee, the agency shall  
2498 adopt a preferred drug list as described in s. 409.912(8)  
2499 ~~409.912(37)~~. To the extent feasible, the committee shall review  
2500 all drug classes included on the preferred drug list every 12  
2501 months, and may recommend additions to and deletions from the  
2502 preferred drug list, such that the preferred drug list provides  
2503 for medically appropriate drug therapies for Medicaid patients  
2504 which achieve cost savings contained in the General  
2505 Appropriations Act.

2506 Reviser's note.—Amended to conform to the redesignation of  
2507 subunits of s. 409.912 by this act.

2508 Section 27. Subsection (1) of section 409.91196, Florida  
2509 Statutes, is amended to read:

2510 409.91196 Supplemental rebate agreements; public records  
2511 and public meetings exemption.—

2512 (1) The rebate amount, percent of rebate, manufacturer's  
2513 pricing, and supplemental rebate, and other trade secrets as  
2514 defined in s. 688.002 that the agency has identified for use in  
2515 negotiations, held by the Agency for Health Care Administration  
2516 under s. 409.912(8)(a)7. ~~409.912(37)(a)7.~~ are confidential and  
2517 exempt from s. 119.07(1) and s. 24(a), Art. I of the State  
2518 Constitution.

2519 Reviser's note.—Amended to conform to the redesignation of  
2520 subunits of s. 409.912 by this act.

2521 Section 28. Subsections (1), (6), (12), and (13) of section  
2522 409.962, Florida Statutes, are amended to read:

2523 409.962 Definitions.—As used in this part, except as

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2524 otherwise specifically provided, the term:

2525 (1) "Accountable care organization" means an entity  
2526 qualified as an accountable care organization in accordance with  
2527 federal regulations, and which meets the requirements of a  
2528 provider service network as described in s. 409.912(2)  
2529 ~~409.912(4)(d)~~.

2530 (6) "Eligible plan" means a health insurer authorized under  
2531 chapter 624, an exclusive provider organization authorized under  
2532 chapter 627, a health maintenance organization authorized under  
2533 chapter 641, or a provider service network authorized under s.  
2534 409.912(2) ~~409.912(4)(d)~~ or an accountable care organization  
2535 authorized under federal law. For purposes of the managed  
2536 medical assistance program, the term also includes the  
2537 Children's Medical Services Network authorized under chapter 391  
2538 and entities qualified under 42 C.F.R. part 422 as Medicare  
2539 Advantage Preferred Provider Organizations, Medicare Advantage  
2540 Provider-sponsored Organizations, Medicare Advantage Health  
2541 Maintenance Organizations, Medicare Advantage Coordinated Care  
2542 Plans, and Medicare Advantage Special Needs Plans, and the  
2543 Program of All-inclusive Care for the Elderly.

2544 (12) "Prepaid plan" means a managed care plan that is  
2545 licensed or certified as a risk-bearing entity, or qualified  
2546 pursuant to s. 409.912(2) ~~409.912(4)(d)~~, in the state and is  
2547 paid a prospective per-member, per-month payment by the agency.

2548 (13) "Provider service network" means an entity qualified  
2549 pursuant to s. 409.912(2) ~~409.912(4)(d)~~ of which a controlling  
2550 interest is owned by a health care provider, or group of  
2551 affiliated providers, or a public agency or entity that delivers  
2552 health services. Health care providers include Florida-licensed

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2553 health care professionals or licensed health care facilities,  
 2554 federally qualified health care centers, and home health care  
 2555 agencies.

2556 Reviser's note.—Amended to conform to the redesignation of  
 2557 subunits of s. 409.912 by this act.

2558 Section 29. Section 636.0145, Florida Statutes, is amended  
 2559 to read:

2560 636.0145 Certain entities contracting with Medicaid.—  
 2561 ~~Notwithstanding the requirements of s. 409.912(4)(b),~~ An entity  
 2562 that is providing comprehensive inpatient and outpatient mental  
 2563 health care services to certain Medicaid recipients in  
 2564 Hillsborough, Highlands, Hardee, Manatee, and Polk Counties  
 2565 through a capitated, prepaid arrangement pursuant to the federal  
 2566 waiver provided for in s. 409.905(5) must become licensed under  
 2567 this chapter by December 31, 1998. Any entity licensed under  
 2568 this chapter which provides services solely to Medicaid  
 2569 recipients under a contract with Medicaid is exempt from ss.  
 2570 636.017, 636.018, 636.022, 636.028, 636.034, and 636.066(1).

2571 Reviser's note.—Amended to conform to the deletion of s.

2572 409.912(4)(b) by this act to conform to its expiration  
 2573 pursuant to its own terms, effective October 1, 2014.

2574 Section 30. Subsection (22) of section 641.19, Florida  
 2575 Statutes, is amended to read:

2576 641.19 Definitions.—As used in this part, the term:

2577 (22) "Provider service network" means a network authorized  
 2578 under s. 409.912(2) ~~409.912(4)(d)~~, reimbursed on a prepaid  
 2579 basis, operated by a health care provider or group of affiliated  
 2580 health care providers, and which directly provides health care  
 2581 services under a Medicare, Medicaid, or Healthy Kids contract.

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2582 Reviser's note.—Amended to conform to the redesignation of  
 2583 subunits of s. 409.912 by this act.

2584 Section 31. Subsection (3) of section 641.225, Florida  
 2585 Statutes, is amended to read:

2586 641.225 Surplus requirements.—

2587 ~~(3) (a) An entity providing prepaid capitated services which~~  
 2588 ~~is authorized under s. 409.912(4) (a) and which applies for a~~  
 2589 ~~certificate of authority is subject to the minimum surplus~~  
 2590 ~~requirements set forth in subsection (1), unless the entity is~~  
 2591 ~~backed by the full faith and credit of the county in which it is~~  
 2592 ~~located.~~

2593 ~~(b) An entity providing prepaid capitated services which is~~  
 2594 ~~authorized under s. 409.912(4) (b) or (c), and which applies for~~  
 2595 ~~a certificate of authority is subject to the minimum surplus~~  
 2596 ~~requirements set forth in s. 409.912.~~

2597 Reviser's note.—Amended to conform to the expiration of  
 2598 paragraphs (4) (a)-(c) of s. 409.912 pursuant to their own  
 2599 terms, effective October 1, 2014, and confirmation of the  
 2600 expiration by this act.

2601 Section 32. Subsection (4) of section 641.386, Florida  
 2602 Statutes, is amended to read:

2603 641.386 Agent licensing and appointment required;  
 2604 exceptions.—

2605 (4) All agents and health maintenance organizations shall  
 2606 comply with and be subject to the applicable provisions of ss.  
 2607 641.309 and 409.912(5) ~~409.912(20)~~, and all companies and  
 2608 entities appointing agents shall comply with s. 626.451, when  
 2609 marketing for any health maintenance organization licensed  
 2610 pursuant to this part, including those organizations under

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2611 contract with the Agency for Health Care Administration to  
2612 provide health care services to Medicaid recipients or any  
2613 private entity providing health care services to Medicaid  
2614 recipients pursuant to a prepaid health plan contract with the  
2615 Agency for Health Care Administration.  
2616 Reviser's note.—Amended to conform to the redesignation of  
2617 subunits of s. 409.912 by this act.  
2618 Section 33. This act shall take effect on the 60th day  
2619 after adjournment sine die of the session of the Legislature in  
2620 which enacted.