Journal of the Senate

Number 24—Regular Session **Friday, March 11, 2022**

CONTENTS

CALL TO ORDER

The Senate was called to order by President Simpson at 9:00 a.m. A quorum present—38:

Mr. President	Cruz	Perry
Albritton	Diaz	Pizzo
Ausley	Farmer	Polsky
Baxley	Gainer	Powell
Bean	Garcia	Rodrigues
Berman	Gibson	Rodriguez
Book	Gruters	Rouson
Boyd	Harrell	Stargel
Bradley	Hooper	Stewart
Brandes	Hutson	Taddeo
Brodeur	Jones	Torres
Broxson	Mayfield	Wright
Burgess	Passidomo	

PRAYER

The following prayer was offered by Senator Bean:

Heavenly God, this is the day that you have made; let us rejoice and be glad in it. We ask a blessing on the House and Senate, their families, the travels of this weekend, and coming back here Monday. We ask a blessing on our health because without health we don't have anything. Bless our staff and their families. Let us be mindful of the soldiers that have defended our liberties and have given their lives—like the one that Senator Burgess introduced, Carl Enis, his family, and know the pain that they have is forever. Just be with them and comfort them. We ask a blessing on our budget and the mission of our budget, and be mindful that every line on our budget there are people, families, children, at the end of that line. We ask the blessing on the budget that it goes to where it's intended to go and that it has a mission to lift those people up and to protect. We ask a blessing on those that have been affected by our fires in the Panhandle. Just comfort those that have lost. We ask a blessing on those in Ukraine. It's horrible the suffering that we see. Just bless those in Ukraine. We ask for a quick, peaceful resolution. All this we ask in your name, and everybody says together, Amen.

PLEDGE

Senate Pages, Emmie Giles of Gulf Breeze, grandaughter of Senator Broxson; Melissa Naters of Palm Bay; and Christopher Ramsey of Alachua, led the Senate in the Pledge of Allegiance to the flag of the United States of America.

DOCTOR OF THE DAY

The President recognized Dr. Philip Ham of Pensacola, sponsored by Senator Broxson, as the doctor of the day. Dr. Ham specializes in family medicine.

ADOPTION OF RESOLUTIONS

At the request of Senator Rouson—

By Senator Rouson—

SR 2000—A resolution honoring *La Gaceta*, one of the oldest minority-owned and -focused newspapers, and the only trilingual newspaper in the United States, for 100 years of continued service to Florida's Latino community.

WHEREAS, *La Gaceta*, the Spanish-language daily newspaper, was founded by Victoriano Manteiga, who immigrated in 1913 from Cuba to West Tampa to accept a job in the Morgan Cigar Factory reading books and newspapers aloud to the *torcedores*, or cigar rollers, while they worked, and

WHEREAS, in 1922, Victoriano Manteiga discussed his idea of publishing a Spanish-language newspaper with Dr. Jose Avellanal, an admired doctor and humanitarian, who contacted the Mascunana Printers, and their combined efforts yielded the first issue of *La Gaceta*, published on May 22, 1922, which went on to be published 6 days per week in Ybor City, with wire service from Cuba and Spain, and

WHEREAS, *La Gaceta* was born from the need to educate, inform, and entertain the Latino community living and working in Ybor City and West Tampa, filling a void created by the Anglo-owned press which, at the time, mostly ignored immigrants or reported negatively about their activities, and

WHEREAS, the newspaper championed causes important to Florida's Latino community, such as the rights of laborers, access to education and recreation, gaining a voice in politics, supporting the Republic in the Spanish Civil War, and an independent Cuba free from corruption, and

WHEREAS, the newspaper survived the Great Depression and the rationing of lead and newsprint in World War II by the perseverance of the Manteiga family and support of the community, and

WHEREAS, at the outbreak of World War II, Victoriano Manteiga's son, Roland, who worked at *La Gaceta*, volunteered to serve in the United States Army and was shipped out with many Tampa Latinos to the Pacific Theatre, leaving Victoriano Manteiga to struggle with publishing the newspaper in his son's absence, and

WHEREAS, after the war, *La Gaceta*'s readership and advertising suffered due to the collapse of the cigar industry in Tampa and the migration of the Latino community to the suburbs, with opportunities for Latinos and the descendants of the original immigrants from Spain, Cuba, and Italy more dependent on the English language than Spanish, and

WHEREAS, to adjust to these changes, *La Gaceta* became a weekly paper in 1953, and in 1954, English-language and Italian-language articles began to appear in its pages, making it a trilingual publication, and

WHEREAS, on June 11, 1954, Roland Manteiga began writing his weekly political gossip column, "As We Heard It," which became a must-read for inside information in government and politics and served as a voice for Tampa's Hispanic community for more than 40 years, and

WHEREAS, in the 1960s, Ybor City hit a low point due to the destruction of the community by urban renewal and the construction of the interstates in Tampa, leaving the Latin Quarter a shadow of itself, although *La Gaceta* remained, documenting the area's history and demise and fighting for its future, and

WHEREAS, with Roland Manteiga at the helm, *La Gaceta* was instrumental in bringing Hillsborough Community College, the Hillsborough County Sheriff's Office, and the Environmental Protection Commission to Ybor City, all of which help keep it alive, and

WHEREAS, Roland Manteiga became an influencer for those seeking to be elected to office, with many national, state, and local leaders paying him visits, and with son Patrick Manteiga by his side starting in 1983, he used this and *La Gaceta*'s influence to promote Ybor City's renaissance and to help save historic buildings that housed the mutual aid societies, Circulo Cubano, Centro Asturiano, and L'Unione Italiana, and

WHEREAS, after Roland Manteiga's passing on September 25, 1998, his son, Patrick Manteiga, took over as publisher and today continues the tradition of his father's "As We Heard It" column and of the newspaper as a voice of the Latino community while keeping an eye on the powers that be, and

WHEREAS, now for more than a century, *La Gaceta*, one of the oldest minority-owned and -focused newspapers, and the only trilingual newspaper, in the United States, continues to serve Citrus, Hillsborough, Hernando, Manatee, Orange, Osceola, Pasco, Pinellas, Polk, and Sarasota Counties, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

That the Florida Senate honors *La Gaceta* newspaper for 100 years of continued service to Florida's Latino community.

—was introduced, read, and adopted by publication.

REPORTS OF COMMITTEE RELATING TO EXECUTIVE BUSINESS

The Honorable Wilton Simpson March 11, 2022
President, The Florida Senate

Dear President Simpson:

The following executive appointment was referred to the Senate Committee on Environment and Natural Resources and the Senate Committee on Ethics and Elections for action pursuant to Rule 12.7 of the Rules of the Florida Senate:

Office and Appointment	*For Term Ending*
Secretary of Environmental Protection	
Appointee: Hamilton, Emile DeShawn	Pleasure of Governor

As required by Rule 12.7, the committees caused to be conducted an inquiry into the qualifications, experience, and general suitability of the above-named appointee for appointment to the office indicated. In aid of such inquiry, the committees held public hearings at which members of the public were invited to attend and offer evidence concerning the qualifications, experience, and general suitability of the appointee. After due consideration of the findings of such inquiry and the evidence adduced at the public hearings, the Committee on Ethics and Elections and other referenced committee respectfully advise and recommend that in accordance with s. 114.05(1)(c), Florida Statutes:

(1) the executive appointment of the above-named appointee, to the office and for the term indicated, be confirmed by the Senate;

(2) Senate action on said appointment be taken prior to the adjournment of the 2022 Regular Session; and

(3) there is no necessity known to the committees for the deliberations on said appointment to be held in executive session.

Respectfully submitted,
Dennis Baxley, Chair

On motion by Senator Baxley, the report was adopted and the Senate confirmed the appointment identified in the foregoing report of the committee to the office and for the term indicated in accordance with the recommendation of the committee.

The vote was:

Yeas—35

Mr. President	Cruz	Pizzo
Albritton	Diaz	Polsky
Ausley	Gainer	Powell
Baxley	Garcia	Rodrigues
Bean	Gibson	Rodriguez
Berman	Gruters	Rouson
Book	Harrell	Stargel
Boyd	Hooper	Stewart
Bradley	Jones	Taddeo
Brandes	Mayfield	Torres
Brodeur	Passidomo	Wright
Burgess	Perry	

Nays—None

Vote after roll call:

Nay—Farmer

INTRODUCTION OF RESOLUTIONS

FIRST READING

On motion by Senator Passidomo—

By Senator Passidomo—

SCR 2002—A concurrent resolution extending the 2022 Regular Session of the Florida Legislature under the authority of Section 3(d), Article III of the State Constitution.

WHEREAS, the 60 days of the 2022 Regular Session of the Florida Legislature will expire on Friday, March 11, 2022, and the necessary tasks of the session have not been completed, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida, the House of Representatives Concurring:

That, the 2022 Regular Session of the Florida Legislature is extended until 11:59 p.m. on Monday, March 14, 2022, under the authority of Section 3(d), Article III of the State Constitution.

BE IT FURTHER RESOLVED that, in the regular session so extended, the Legislature shall consider only the following matters:

(1) House Bill 5001 or any Senate and House Conference Committee Report thereon.

(2) House Bill 5003 or any Senate and House Conference Committee Report thereon.

(3) House Bill 5005 or any Senate and House Conference Committee Report thereon.

(4) House Bill 5007 or any Senate and House Conference Committee Report thereon.

(5) House Bill 5009 or any Senate and House Conference Committee Report thereon.

(6) House Bill 5011 or any Senate and House Conference Committee Report thereon.

(7) House Bill 5301 or any Senate and House Conference Committee Report thereon.

(8) Committee Substitute for House Bill 7027 or any Senate and House Conference Committee Report thereon.

(9) Committee Substitute for House Bill 7071 or any Senate and House Conference Committee Report thereon.

(10) Senate Bill 2508 or any Senate and House Conference Committee Report thereon.

(11) Senate Bill 2510 or any Senate and House Conference Committee Report thereon.

(12) Senate Bill 2512 or any Senate and House Conference Committee Report thereon.

(13) Senate Bill 2514 or any Senate and House Conference Committee Report thereon.

(14) Senate Bill 2516 or any Senate and House Conference Committee Report thereon.

(15) Senate Bill 2518 or any Senate and House Conference Committee Report thereon.

(16) Senate Bill 2524 or any Senate and House Conference Committee Report thereon.

(17) Senate Bill 2526 or any Senate and House Conference Committee Report thereon.

(18) Senate Bill 2530 or any Senate and House Conference Committee Report thereon.

BE IT FURTHER RESOLVED that all other measures in both houses are indefinitely postponed and withdrawn from consideration of the respective house as of 12:00 a.m., Saturday, March 12, 2022.

BE IT FURTHER RESOLVED that upon recess or adjournment on Friday, March 11, 2022, either house may reconvene upon the call of its presiding officer.

BE IT FURTHER RESOLVED that the Legislature shall adjourn sine die at the earlier of Monday, March 14, 2022, at 11:59 p.m. or upon concurrent motions to adjourn sine die.

—was introduced and read by title. On motion by Senator Passidomo, **SCR 2002** was read the second time in full, adopted by the required constitutional three-fifths vote of the members present and voting, and certified to the House.

MESSAGES FROM THE HOUSE OF REPRESENTATIVES

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has passed SB 312, with 1 amendment (667321), and requests the concurrence of the Senate.

Jeff Takacs, Clerk

SB 312—A bill to be entitled An act relating to telehealth; amending s. 456.47, F.S.; revising the definition of the term "telehealth"; narrowing the prohibition on prescribing controlled substances through telehealth to include only specified controlled substances; providing an effective date.

House Amendment 1 (667321) (with directory and title amendments)—Remove lines 15-23

And the directory clause is amended as follows:

Remove lines 11-12 and insert: Section 1. Paragraph (c) of subsection (2) of section 456.47, Florida Statutes, is

And the title is amended as follows:

Remove lines 3-5 and insert: F.S.; revising the prohibition on prescribing controlled substances through the use of telehealth to include

On motion by Senator Diaz, the Senate concurred in **House Amendment 1 (667321)**.

SB 312 passed, as amended, was ordered engrossed and then enrolled. The action of the Senate was certified to the House. The vote on passage was:

Yeas—37

Mr. President	Cruz	Pizzo
Albritton	Diaz	Polsky
Ausley	Gainer	Powell
Baxley	Garcia	Rodrigues
Bean	Gibson	Rodriguez
Berman	Gruters	Rouson
Book	Harrell	Stargel
Boyd	Hooper	Stewart
Bradley	Hutson	Taddeo
Brandes	Jones	Torres
Brodeur	Mayfield	Wright
Broxson	Passidomo	
Burgess	Perry	

Nays—None

Vote after roll call:

Yea—Farmer

SENATOR PASSIDOMO PRESIDING

THE PRESIDENT PRESIDING

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has passed CS/SB 898, with 1 amendment (469845), and requests the concurrence of the Senate.

Jeff Takacs, Clerk

CS for SB 898—A bill to be entitled An act relating to tenant safety; providing a short title; creating s. 83.515, F.S.; requiring landlords of nontransient or transient apartments to require employees to undergo background screenings as a condition of employment; specifying requirements for the employee background screenings; authorizing landlords to disqualify persons from employment under certain circumstances relating to criminal offenses; amending s. 83.53, F.S.; revising what constitutes reasonable notice for repairs of dwelling units; amending s. 509.211, F.S.; requiring public lodging establishments licensed as nontransient or transient apartments to take certain actions relating to employee background screenings and keys for dwelling units; requiring such establishments to provide proof of compliance to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation upon request; providing effective dates.

House Amendment 1 (469845) (with title amendment)—Remove lines 93-94 and insert:

Section 5. Effective upon this act becoming a law, section 509.098, Florida Statutes, is created to read:

509.098 Prohibition of hourly rates.—

(1) An operator of a public lodging establishment may not offer an hourly rate for an accommodation.

(2) This section does not apply to an hourly rate charged by an operator of a public lodging establishment as a late checkout fee.

Section 6. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2022

And the title is amended as follows:

Remove lines 2-19 and insert: An act relating to lodging standards; providing a short title; creating s. 83.515, F.S.; requiring landlords of nontransient or transient apartments to require employees to undergo background screenings as a condition of employment; specifying requirements for the employee background screenings; authorizing landlords to disqualify persons from employment under certain circumstances relating to criminal offenses; amending s. 83.53, F.S.; revising what constitutes reasonable notice for repairs of dwelling units; reasonable notice for repairs of dwelling units; amending s. 509.211, F.S.; requiring public lodging establishments licensed as nontransient or transient apartments to take certain actions relating to employee background screenings and keys for dwelling units; requiring such establishments to provide proof of compliance to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation upon request; creating s. 509.098, F.S.; prohibiting an operator of a public lodging establishment from offering an hourly rate for an accommodation; providing applicability; providing

On motion by Senator Stewart, the Senate concurred in **House Amendment 1 (469845)**.

CS for SB 898 passed, as amended, was ordered engrossed and then enrolled. The action of the Senate was certified to the House. The vote on passage was:

Yeas—34

Albritton	Gainer	Polsky
Bean	Garcia	Powell
Berman	Gibson	Rodrigues
Book	Gruters	Rodriguez
Boyd	Harrell	Rouson
Bradley	Hooper	Stargel
Brandes	Hutson	Stewart
Brodeur	Jones	Taddeo
Broxson	Mayfield	Torres
Burgess	Passidomo	Wright
Cruz	Perry	
Diaz	Pizzo	

Nays—None

Vote after roll call:

Yea—Mr. President, Baxley

SENATOR PASSIDOMO PRESIDING

THE PRESIDENT PRESIDING

SENATOR BEAN PRESIDING

THE PRESIDENT PRESIDING

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has amended Senate Amendment 1 (541410) with House Amendment 1 (922297), concurred in the same as amended, and passed CS/HB 95 as further amended, and requests the concurrence of the Senate.

Jeff Takacs, Clerk

By Criminal Justice & Public Safety Subcommittee and Representative(s) Plakon, Barnaby—

CS for HB 95—A bill to be entitled An act relating to controlled substance offenses; amending s. 782.04, F.S.; revising the elements that constitute the capital offense of murder in the first degree; conforming provisions to changes made by the act; defining the term "substantial factor"; amending s. 893.13, F.S.; prohibiting specified activities involving controlled substances within 1,000 feet of additional specified facilities; providing criminal penalties; providing an effective date.

House Amendment 1 (922297) (with title amendment) to Senate Amendment 1 (541410)—Remove lines 96-314 of the amendment and insert:

Section 2. Paragraph (h) of subsection (1) of section 893.13, Florida Statutes, is amended to read:

893.13 Prohibited acts; penalties.—

(1)

(h) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising *a mental health facility, as that term is used in chapter 394; a health care facility licensed under chapter 395 which provides substance abuse treatment; a licensed service provider as defined in s. 397.311; a facility providing services that include clinical treatment, intervention, or prevention as described in s. 397.311(26); a recovery residence as defined in s. 397.311;* an assisted living facility~~,~~ as *defined* ~~that term is used~~ in chapter 429*; or a pain management clinic as defined in s. 458.3265(1)(a)1.c. or s. 459.0137(1)(a)1.c.* A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

Section 3. Paragraph (c) of subsection (1) of section 893.135, Florida Statutes, is amended to read:

893.135 Trafficking; mandatory sentences; suspension or reduction of sentences; conspiracy to engage in trafficking.—

(1) Except as authorized in this chapter or in chapter 499 and notwithstanding the provisions of s. 893.13:

(c)1. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of any morphine, opium, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 4 grams or more of any mixture containing any such substance, but less than 30 kilograms of such substance or mixture, commits a felony of the first degree, which felony shall be known as "trafficking in illegal drugs," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $100,000.

c. Is 28 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $500,000.

2. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 28 grams or more of hydrocodone, as described in s. 893.03(2)(a)1.k., codeine, as described in s. 893.03(2)(a)1.g., or any salt thereof, or 28 grams or more of any mixture containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in hydrocodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 28 grams or more, but less than 50 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 50 grams or more, but less than 100 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 100 grams or more, but less than 300 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

d. Is 300 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

3. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 7 grams or more of oxycodone, as described in s. 893.03(2)(a)1.q., or any salt thereof, or 7 grams or more of any mixture containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in oxycodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 7 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 25 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 25 grams or more, but less than 100 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

d. Is 100 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

4.a. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of:

(I) Alfentanil, as described in s. 893.03(2)(b)1.;

(II) Carfentanil, as described in s. 893.03(2)(b)6.;

(III) Fentanyl, as described in s. 893.03(2)(b)9.;

(IV) Sufentanil, as described in s. 893.03(2)(b)30.;

(V) A fentanyl derivative, as described in s. 893.03(1)(a)62.;

(VI) A controlled substance analog, as described in s. 893.0356, of any substance described in sub-sub-subparagraphs (I)-(V); or

(VII) A mixture containing any substance described in sub-sub-subparagraphs (I)-(VI),

commits a felony of the first degree, which felony shall be known as "trafficking in *dangerous* fentanyl *or fentanyl analogues*," punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

b. If the quantity involved under sub-subparagraph a.:

(I) Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of *7* ~~3~~ years, and shall be ordered to pay a fine of $50,000.

(II) Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of *20* ~~15~~ years, and shall be ordered to pay a fine of $100,000.

(III) Is 28 grams or more, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years, and shall be ordered to pay a fine of $500,000.

5. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 30 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 30 kilograms or more of any mixture containing any such substance, commits the first degree felony of trafficking in illegal drugs. A person who has been convicted of the first degree felony of trafficking in illegal drugs under this subparagraph shall be punished by life imprisonment and is ineligible for any form of discretionary early release except pardon or executive clemency or conditional medical release under s. 947.149. However, if the court determines that, in addition to committing any act specified in this paragraph:

a. The person intentionally killed an individual or counseled, commanded, induced, procured, or caused the intentional killing of an individual and such killing was the result; or

b. The person's conduct in committing that act led to a natural, though not inevitable, lethal result,

such person commits the capital felony of trafficking in illegal drugs, punishable as provided in ss. 775.082 and 921.142. A person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

6. A person who knowingly brings into this state 60 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 60 kilograms or more of any mixture containing any such substance, and who knows that the probable result of such importation would be the death of a person, commits capital importation of illegal drugs, a capital felony punishable as provided in ss. 775.082 and 921.142. A person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

And the title is amended as follows:

Remove lines 327-340 of the amendment and insert: 893.13, F.S.; prohibiting specified activities involving controlled substances within 1,000 feet of additional specified facilities; providing criminal penalties; amending s. 893.135, F.S.; renaming what the violation of specified offenses are known as from "trafficking in fentanyl" to "trafficking in dangerous fentanyl or fentanyl analogues"; increasing the mandatory minimum terms of imprisonment for specified offenses; providing an effective date.

On motion by Senator Brodeur, the Senate concurred in **House Amendment 1 (922297) to Senate Amendment 1 (541410)**.

CS for HB 95 passed, as amended, and the action of the Senate was certified to the House. The vote on passage was:

Yeas—33

Mr. President	Cruz	Perry
Albritton	Diaz	Pizzo
Ausley	Gainer	Polsky
Baxley	Garcia	Rodrigues
Bean	Gruters	Rodriguez
Book	Harrell	Rouson
Boyd	Hooper	Stargel
Bradley	Hutson	Stewart
Brodeur	Jones	Taddeo
Broxson	Mayfield	Torres
Burgess	Passidomo	Wright

Nays—5

Berman	Farmer	Powell
Brandes	Gibson	

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has amended Senate Amendment 1 (504356) with House Amendment 1 (365861), concurred in the same as amended, and passed CS/HB 615 as further amended, and requests the concurrence of the Senate.

Jeff Takacs, Clerk

By Criminal Justice & Public Safety Subcommittee and Representative(s) Overdorf, Chaney—

CS for HB 615—A bill to be entitled An act relating to human trafficking; amending s. 16.618, F.S.; deleting an obsolete provision; requiring the direct-support organization of the Statewide Council on Human Trafficking to develop certain training for firesafety inspectors; providing that such training is eligible for continuing education credits; providing an effective date.

House Amendment 1 (365861) to Senate Amendment 1 (504356)—Remove lines 17-19 of the amendment and insert:
used for such purposes.

On motion by Senator Garcia, the Senate concurred in **House Amendment 1 (365861) to Senate Amendment 1 (504356)**.

CS for HB 615 passed, as amended, and the action of the Senate was certified to the House. The vote on passage was:

Yeas—38

Mr. President	Cruz	Perry
Albritton	Diaz	Pizzo
Ausley	Farmer	Polsky
Baxley	Gainer	Powell
Bean	Garcia	Rodrigues
Berman	Gibson	Rodriguez
Book	Gruters	Rouson
Boyd	Harrell	Stargel
Bradley	Hooper	Stewart
Brandes	Hutson	Taddeo
Brodeur	Jones	Torres
Broxson	Mayfield	Wright
Burgess	Passidomo	

Nays—None

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has passed CS/CS/SB 1950, with 1 amendment, and requests the concurrence of the Senate.

Jeff Takacs, Clerk

CS for CS for SB 1950—A bill to be entitled An act relating to the statewide Medicaid managed care program; amending s. 409.912, F.S.; requiring, rather than authorizing, that the reimbursement method for provider service networks be on a prepaid basis; deleting the authority to reimburse provider service networks on a fee-for-service basis; conforming provisions to changes made by the act; providing that provider service networks are subject to and exempt from certain requirements; providing construction; repealing s. 409.9124, F.S., relating to managed care reimbursement; amending s. 409.964, F.S.; deleting a requirement that the Agency for Health Care Administration provide the opportunity for public feedback on a certain waiver application; amending s. 409.966, F.S.; revising requirements relating to the databook published by the agency consisting of Medicaid utilization and spending data; reallocating regions within the statewide managed care program; deleting a requirement that the agency negotiate plan rates or payments to guarantee a certain savings amount; deleting a requirement for the agency to award additional contracts to plans in specified regions for certain purposes; revising a limitation on when plans may begin serving Medicaid recipients to apply to any eligible plan that participates in an invitation to negotiate, rather than plans participating in certain regions; making technical changes; amending s. 409.967, F.S.; deleting obsolete provisions; amending s. 409.968, F.S.; conforming provisions to changes made by the act; amending s. 409.973, F.S.; revising requirements for healthy behaviors programs established by plans; deleting an obsolete provision; amending s. 409.974, F.S.; requiring the agency to select plans for the managed medical assistance program through a single statewide procurement; authorizing the agency to award contracts to plans on a regional or statewide basis; specifying requirements for minimum numbers of plans which the agency must procure for each specified region; conforming provisions to changes made by the act; deleting procedures for plan procurements when no provider service networks submit bids; making technical changes; deleting a requirement for the agency to exercise a preference for certain plans; amending s. 409.975, F.S.; providing that cancer hospitals meeting certain criteria are statewide essential providers; requiring payments to such hospitals to equal a certain rate; amending s. 409.977, F.S.; revising the circumstances for maintaining a recipient's enrollment in a plan; deleting obsolete language; authorizing specialty plans to serve certain children who receive guardianship assistance payments under the Guardianship Assistance Program; amending s. 409.981, F.S.; requiring the agency to select plans for the long-term care managed medical assistance program through a single statewide procurement; authorizing the agency to award contracts to plans on a regional or statewide basis; specifying requirements for minimum numbers of plans which the agency must procure for each specified region; conforming provisions to changes made by the act; deleting procedures for plan procurements when no provider service networks submit bids; amending s. 409.8132, F.S.; conforming a cross-reference; reenacting ss. 409.962(1), (7), (13), and (14) and 641.19(22) relating to definitions, to incorporate the amendments made by this act to s. 409.912, F.S., in references thereto; reenacting s. 430.2053(3)(h), (i), and (j) and (11), relating to aging resource centers, to incorporate the amendments made by this act to s. 409.981, F.S., in references thereto; requiring the agency to amend existing Statewide Medicaid Managed Care contracts to implement changes made by the act; requiring the agency to implement changes made by the act for a specified plan year; providing an effective date.

House Amendment 1 (739505) (with title amendment)—Remove everything after the enacting clause and insert:

Section 1. Subsection (26) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(26) The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments and Low Income Pool Program payments, including

federal matching funds. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency. To be eligible for low-income pool funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, essential providers identified in *s. 409.975(1)(a)* ~~s. 409.975(1)(a)2.~~ must *have a network* ~~offer to~~ contract with each managed care plan in their region and essential providers identified in *s. 409.975(1)(b)* ~~s. 409.975(1)(b)1. and 3.~~ must *have a network* ~~offer to~~ contract with each managed care plan in the state. Before releasing such supplemental payments, ~~in the event the parties have not executed network contracts,~~ the agency shall *determine whether such contracts are in place and* ~~evaluate the parties' efforts to complete negotiations. If such efforts continue to fail, the agency must~~ withhold such supplemental payments beginning *no later than January 1 of each fiscal year for essential providers without such contracts in place. By the end of each fiscal year, the agency shall identify essential providers who have not executed required network contracts with the applicable managed care plans for the next fiscal year. By July 30, such providers and plans must enter into mediation and jointly notify the agency of mediation commencement. Selection of a mediator must be by mutual agreement of the plan and provider, or, if they cannot agree, by the agency from a list of at least four mediators submitted by the parties. The costs of the mediation shall be borne equally by the parties. The mediation must be completed before September 30. On or before October 1, the mediator must submit a written postmediation report to the agency, including the outcome of the mediation and, if mediation resulted in an impasse, conclusions and recommendations as to the cause of the impasse, the party most responsible for the impasse, and whether the mediator believes that either party negotiated in bad faith. If the mediator recommends to the agency that a party or both parties negotiated in bad faith, the postmediation report must state the basis for such recommendation, cite all relevant information forming the basis of the recommendation, and attach any relevant documentation. The agency must promptly publish all postmediation reports on its website* ~~in the third quarter of the fiscal year if it determines that, based upon the totality of the circumstances, the essential provider has negotiated with the managed care plan in bad faith. If the agency determines that an essential provider has negotiated in bad faith, it must notify the essential provider at least 90 days in advance of the start of the third quarter of the fiscal year and afford the essential provider hearing rights in accordance with chapter 120~~.

Section 2. Subsection (1) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(1) The agency may contract with a provider service network, which *must* ~~may~~ be reimbursed on a ~~fee-for-service or~~ prepaid basis. ~~Prepaid~~ Provider service networks shall receive per-member, per-month payments. ~~A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.~~

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

(b) A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of

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

(c) This subsection does not authorize the agency to contract with a provider service network outside of the procurement process described in s. 409.966.

Section 3. *Section 409.9124, Florida Statutes, is repealed.*

Section 4. Section 409.964, Florida Statutes, is amended to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. ~~Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.~~

Section 5. Paragraph (f) of subsection (3) of section 409.966, Florida Statutes, is redesignated as paragraph (d), and subsection (2), present paragraphs (a), (d), and (e) of subsection (3), and subsection (4) of that section are amended to read:

409.966 Eligible plans; selection.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(1)(c). At least 90 days before issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data *consistent with actuarial rate-setting practices and standards* ~~for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region or county~~. The source of the data in the *databook* ~~report~~ must include*, at a minimum, the most recent 24 months of* ~~both historic fee-for-service claims and~~ validated data from the Medicaid Encounter Data System*, and the databook must*~~. The report must be available in electronic form and~~ delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score. *The agency shall conduct a single, statewide procurement, shall negotiate and select plans on a regional basis, and may select plans on a statewide basis if deemed the best value for the state and Medicaid recipients. Plan selection* ~~separate and simultaneous procurements~~ shall be conducted in each of the following regions:

(a) Region A, which consists of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington Counties.

(b) Region B, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia Counties.

(c) Region C, which consists of Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk Counties.

(d) Region D, which consists of Brevard, Orange, Osceola, and Seminole Counties.

(e) Region E, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties.

(f) Region F, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

(g) Region G, which consists of Broward County.

(h) Region H, which consists of Miami-Dade and Monroe Counties.

~~(a) Region 1, which consists of Escambia, Okaloosa, Santa Rosa, and Walton Counties.~~

~~(b) Region 2, which consists of Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington Counties.~~

~~(c) Region 3, which consists of Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union Counties.~~

~~(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties.~~

~~(e) Region 5, which consists of Pasco and Pinellas Counties.~~

~~(f) Region 6, which consists of Hardee, Highlands, Hillsborough, Manatee, and Polk Counties.~~

~~(g) Region 7, which consists of Brevard, Orange, Osceola, and Seminole Counties.~~

~~(h) Region 8, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties.~~

~~(i) Region 9, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.~~

~~(j) Region 10, which consists of Broward County.~~

~~(k) Region 11, which consists of Miami-Dade and Monroe Counties.~~

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that an eligible plan has *obtained signed contracts or* written agreements ~~or signed contracts~~ or has made substantial progress in establishing relationships with providers before the plan *submits* ~~submitting~~ a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

~~(d) For the first year of the first contract term, the agency shall negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.~~

~~1. For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.~~

~~2. For provider service networks operating on a fee-for-service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee for service basis for the same services in the prior year.~~

~~(e) To ensure managed care plan participation in Regions 1 and 2, the agency shall award an additional contract to each plan with a contract award in Region 1 or Region 2. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency. If a plan that is awarded an additional contract pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(i) for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. the plan must reimburse the agency for the cost of enrollment changes and other transition activities.~~

(4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that participates in an invitation to negotiate ~~in more than one region~~ and is selected ~~in at least one region~~ may not begin serving Medicaid recipients in any region ~~for which it was selected~~ until all administrative challenges to procurements required by this section to which the eligible plan is a party have been finalized. If the number of plans selected is less than the maximum amount of plans permitted in the region, the agency may contract with other selected plans in the region not participating in the administrative challenge before resolution of the administrative challenge. For purposes of this subsection, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

Section 6. Paragraphs (c) and (f) of subsection (2) and paragraph (b) of subsection (4) of section 409.967, Florida Statutes, are amended, and paragraph (k) is added to subsection (3) of that section, to read:

409.967 Managed care plan accountability.—

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

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. ~~A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge.~~ Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that ~~behavioral health~~ providers are accepting enrollees, and confirm that enrollees have *timely* access to *all covered benefits* ~~behavioral health services~~.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(f) Continuous improvement.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

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

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under s. 409.977 and 409.984.

~~4. By the end of the fourth year of the first contract term, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring, including analysis of encounter data, assessment of performance measures, and compliance with other contractual requirements.~~

(3) ACHIEVED SAVINGS REBATE.—

(k) Plans that contribute funds pursuant to paragraph (4)(b) or paragraph (4)(c) may reduce the rebate owed by an amount equal to the amount of the contribution.

(4) MEDICAL LOSS RATIO.—If required as a condition of a waiver, the agency may calculate a medical loss ratio for managed care plans. The calculation shall use uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method for calculating the medical loss ratio shall meet the following criteria:

(b) Funds provided by plans to ~~graduate medical~~ education institutions to underwrite the costs of residency positions *in graduate medical education programs, undergraduate and graduate student positions in nursing education programs, or student positions in any degree or technical program deemed a critical shortage area by the agency* shall be classified as medical expenditures, provided *that* the funding is sufficient to sustain the positions for the number of years necessary to complete the *program* ~~residency~~ requirements and the residency *or student* positions funded by the plans are *actively involved in the institution's provision* ~~active providers~~ of care to Medicaid and uninsured patients.

Section 7. Subsection (2) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(2) Provider service networks *must* ~~may~~ be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. ~~Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of its operation. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period must be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation is considered final.~~

Section 8. Subsection (3) and paragraph (b) of subsection (4) of section 409.973, Florida Statutes, are amended, and paragraphs (c) through (g) are added to subsection (5) of that section, to read:

409.973 Benefits.—

(3) HEALTHY BEHAVIORS.—Each plan operating in the managed medical assistance program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved *tobacco use* ~~smoking~~ cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse recovery program*, which shall include, at a minimum, a focus on opioid abuse recovery*. Each plan must identify enrollees who *use tobacco* ~~smoke~~, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participation in these programs.

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an appointment with the primary care provider. If possible the appointment should be made within 30 days after enrollment in the plan. ~~For enrollees who become eligible for Medicaid between January 1, 2014, and December 31, 2015, the appointment should be scheduled within 6 months after enrollment in the plan.~~

(5) PROVISION OF DENTAL SERVICES.—

(c) Given the effect of oral health on overall health, each prepaid dental plan shall establish a program to improve dental health outcomes and increase utilization of preventive dental services. The agency shall establish performance and outcome measures, regularly assess plan performance, and publish data on such measures. Program components shall, at a minimum, include:

1. An education program to inform enrollees of the connection between oral health and overall health and preventive steps to improve dental health.

2. An enrollee incentive program designed to increase utilization of preventive dental services.

(d) The agency shall annually review encounter data and claims expenditures in the Statewide Medicaid Managed Care program for emergency department visits relating to nontraumatic and ambulatory sensitive dental conditions and reconcile service expenditures for these visits against capitation payments made to the prepaid dental plans.

(e) By October 1, 2022, each prepaid dental plan and each nondental managed care plan shall enter into a mutual coordination of benefits agreement that includes data sharing requirements and coordination protocols to support the provision of dental services and reduction of potentially preventable events.

(f) Beginning July 2022, each prepaid dental plan and each nondental managed care plan must meet quarterly to collaborate on specific goals to improve quality of care and enrollee health. Plans shall mutually establish, in writing, shared goals, specific and measurable objectives, and complementary strategies pertinent to state Medicaid priorities. The goals, objectives, and strategies must address improving access and appropriate utilization, maximizing efficiency by integrating health and dental care, improving patient experiences, attending to unmet social needs that affect preventive care utilization and early disease detection, and identifying and reducing disparities.

(g) The agency shall establish provider network requirements for dental plans. In addition, the agency must establish provider network requirements sufficient to ensure access to medically necessary sedation services, including, but not limited to, network participation by dentists credentialed to provide services in inpatient and outpatient settings and by inpatient and outpatient facilities and anesthesia service providers. The agency shall assess plan compliance with network adequacy requirements at least quarterly and shall enforce such requirements in a timely manner.

Section 9. Subsections (1) and (2) of section 409.974, Florida Statutes, are amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans *for the managed medical assistance program* through the procurement process described in s. 409.966. *The agency shall select at least one provider service network for each region, if any submit a responsive bid. The agency shall procure the number of plans, inclusive of statewide plans, if any, for each region as follows:*

(a) At least three plans and up to four plans for Region A.

(b) At least five plans and up to six plans for Region B.

(c) At least six plans and up to ten plans for Region C.

(d) At least five plans and up to six plans for Region D.

(e) At least three plans and up to four plans for Region E.

(f) At least three plans and up to five plans for Region F.

(g) At least three plans and up to five plans for Region G.

(h) At least five plans and up to ten plans for Region H ~~The agency shall notice invitations to negotiate no later than January 1, 2013~~.

~~(a) The agency shall procure two plans for Region 1. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.~~

~~(b) The agency shall procure two plans for Region 2. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.~~

~~(c) The agency shall procure at least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(d) The agency shall procure at least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(e) The agency shall procure at least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(f) The agency shall procure at least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(g) The agency shall procure at least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(h) The agency shall procure at least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(i) The agency shall procure at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) The agency shall procure at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) The agency shall procure at least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

If no provider service network submits a responsive bid, the agency shall procure no more than one *fewer* ~~less~~ than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in those regions where no provider service network has been selected.

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has *obtained signed contracts or* written agreements ~~or signed contracts~~ or has made substantial progress in establishing relationships with providers before the plan *submits* ~~submitting~~ a response. The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to s. 409.975(1). ~~The agency shall exercise a preference for plans with a provider network in which over 10 percent of the providers use electronic health records, as defined in s. 408.051.~~ When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

Section 10. Paragraphs (a) and (b) of subsection (1) of section 409.975, Florida Statutes, are amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers.

1. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

a.~~1.~~ Federally qualified health centers.

b.~~2.~~ Statutory teaching hospitals as defined in s. 408.07(46).

c.~~3.~~ Hospitals that are trauma centers as defined in s. 395.4001(15).

d.~~4.~~ Hospitals located at least 25 miles from any other hospital with similar services.

2. Regional perinatal intensive care centers as defined in s. 383.16(2) are regional resources and essential providers for all managed care plans in the applicable region. All managed care plans in a region must have a network contract with each regional perinatal intensive care center in the region.

3. Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

The agency shall assess plan compliance with this paragraph at least quarterly. No later than January 1 of each year, the agency must impose contract enforcement financial sanctions on, or assess contract damages against, a plan without a network contract as required by this subsection with an essential provider subject to the requirements of s. 409.908(26).

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks.

1. Statewide essential providers include:

a.~~1.~~ Faculty plans of Florida medical schools.

~~2. Regional perinatal intensive care centers as defined in s. 383.16(2).~~

b.~~3.~~ Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

c. Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v).

~~4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.~~

2. Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals *and payments to nonparticipating Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v)* shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

The agency shall assess plan compliance with this paragraph at least quarterly. No later than January 1 of each year, the agency must impose contract enforcement financial sanctions on, or assess contract damages against, a plan without a network contract as required by this subsection with an essential provider subject to the requirements of s. 409.908(26).

Section 11. Subsections (1), (4), and (5) of section 409.977, Florida Statutes, are amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. *The agency may not automatically enroll recipients in a managed medical assistance plan that has more than 50 percent of the enrollees in the region.* ~~In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available.~~ Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

(4) The agency shall develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage. ~~Contingent upon federal approval,~~ The agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under ~~the Florida Health Choices Program, or~~ any health exchange, to opt out. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient. The agency shall ~~seek federal approval to~~ require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

(5) Specialty plans serving children in the care and custody of the department may serve such children as long as they remain in care, including those remaining in extended foster care pursuant to s. 39.6251, or are in subsidized adoption and continue to be eligible for Medicaid pursuant to s. 409.903*, or are receiving guardianship assistance payments and continue to be eligible for Medicaid pursuant to s. 409.903*.

Section 12. Subsection (2) of section 409.981, Florida Statutes, is amended to read:

409.981 Eligible long-term care plans.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans *for the long-term care managed care program* through the procurement process described in s. 409.966. *The agency shall select at least one provider service network for each region, if any provider service network submits a responsive bid.* The agency shall procure *the number of plans, inclusive of statewide plans, if any, for each region as follows*:

(a) At least three plans and up to four plans for Region A.

(b) At least three plans and up to six plans for Region B.

(c) At least five plans and up to ten plans for Region C.

(d) At least three plans and up to six plans for Region D.

(e) At least three plans and up to four plans for Region E.

(f) At least three plans and up to five plans for Region F.

(g) At least three plans and up to four plans for Region G.

(h) At least five plans and up to ten plans for Region H.

~~(a) Two plans for Region 1. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(b) Two plans for Region 2. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(c) At least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(d) At least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service network submits a responsive bid.~~

~~(e) At least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(f) At least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(g) At least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(h) At least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

If no provider service network submits a responsive bid ~~in a region other than Region 1 or Region 2~~, the agency shall procure no more than one *fewer* ~~less~~ than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.

Section 13. Subsection (4) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.—

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

Section 14. Paragraph (d) of subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

(d) The agency shall seek federal approval to pay for flexible services for persons with severe mental illness or substance use disorders, including, but not limited to, temporary housing assistance. Payments may be made as enhanced capitation rates or incentive payments to managed care plans that meet the requirements of *s. 409.968(3)* ~~s. 409.968(4)~~.

Section 15. *The Agency for Health Care Administration must amend existing contracts under the Statewide Medicaid Managed Care program to implement the amendments made by this act to ss. 409.908, 409.967, 409.973, 409.975, and 409.977, Florida Statutes. The agency must implement the amendments made by this act to ss. 409.966, 409.974, and 409.981, Florida Statutes, for the 2025 plan year.*

Section 16. This act shall take effect July 1, 2022.

And the title is amended as follows:

Remove everything before the enacting clause and insert: A bill to be entitled An act relating to Medicaid managed care; amending s. 409.908, F.S.; requiring the Agency for Health Care Administration to determine compliance with essential provider contracting requirements; requiring the agency to withhold supplemental payments under certain circumstances; requiring the agency to identify certain essential providers by the end of each fiscal year; requiring certain providers and managed care plans to mediate network contracts and jointly notify the agency of mediation commencement by a specified date; specifying requirements for mediation; specifying the content of a written post-mediation report and requiring that such report be submitted to the agency by a specified date; requiring the agency to publish all post-mediation reports on its website; amending s. 409.912, F.S.; requiring the reimbursement of certain provider service networks on a prepaid basis; removing obsolete language related to provider service network reimbursement; providing construction; repealing s. 409.9124, F.S., relating to managed care reimbursement; amending s. 409.964, F.S.; removing obsolete language related to requiring the agency to provide public notice before seeking a Medicaid waiver; amending s. 409.966, F.S.; revising a provision related to a requirement that the agency include certain information in a utilization and spending databook; requiring the agency to conduct a single, statewide procurement and negotiate and select plans on a regional basis; authorizing the agency to select plans on a statewide basis under certain circumstances; specifying the procurement regions; removing obsolete language related to prepaid rates and an additional procurement award; making conforming changes; amending s. 409.967, F.S.; removing obsolete language related to certain hospital contracts; requiring the agency to test provider network databases to confirm that enrollees have timely access to all covered benefits; removing obsolete language related to a request for information; authorizing plans to reduce an achieved savings rebate under certain circumstances; classifying certain expenditures as medical expenses; amending s. 409.968, F.S.; removing obsolete language related to provider service network reimbursement; amending s. 409.973, F.S.; requiring healthy behaviors programs to address tobacco use and opioid abuse; removing obsolete language related to primary care appointments; requiring managed care plans to establish certain programs to improve dental health outcomes; requiring the agency to establish performance and outcome measures; requiring the agency to annually review certain data and expenditures for dental-related emergency department visits and reconcile such expenditures against prepaid dental plan capitation payments; requiring prepaid dental plans and nondental managed care plans to enter into a mutual coordination of benefits agreement for specified purposes by a specified date; requiring prepaid dental plans and nondental managed care plans to meet quarterly for certain purposes beginning on a specified date; specifying the parties' obligations for such meetings; requiring the agency to establish provider network requirements for dental plans, including prepaid dental plan provider network requirements regarding sedation dentistry services; requiring sanctions under certain circumstances; requiring the agency to assess plan compliance at least quarterly and enforce network adequacy requirements in a timely manner; amending s. 409.974, F.S.; establishing numbers of regional contract awards in the Medicaid managed medical assistance program; amending s. 409.975, F.S.; providing that regional perinatal intensive care centers are regional resources and essential providers for managed care plans; requiring managed care plans to contract with such centers; requiring the agency to assess plan compliance with certain requirements at least quarterly; requiring the agency to impose contract enforcement financial sanctions on or assess contract damages against certain plans by a specified date annually; removing regional perinatal intensive care centers from, and including certain cancer hospitals in, the list of statewide essential providers; providing a payment rate for certain cancer hospitals without network contracts; amending s. 409.977, F.S.; prohibiting the agency from automatically enrolling recipients in managed care plans under certain circumstances; removing obsolete language related to automatic enrollment and certain federal approvals; providing that children receiving guardianship assistance payments are eligible for a specialty plan; amending s. 409.981, F.S.; specifying the number of regional contract awards in the long-term care managed care plan; making a conforming change; amending ss. 409.8132 and 409.906, F.S.; conforming cross-references; requiring the agency to amend existing contracts under the Statewide Medicaid Managed Care program to implement specified provisions of the act; requiring the agency to implement specified provisions of the act for the 2025 plan year; providing an effective date.

Senator Brodeur moved the following amendment to **House Amendment 1 (739505)** which was adopted:

Senate Amendment 1 (967698) (with title amendment) to House Amendment 1 (739505)—Delete lines 5-986 and insert:

Section 1. Subsection (1) of section 409.912, Florida Statutes, is amended to read:

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

other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(1) The agency may contract with a provider service network, which *must* ~~may~~ be reimbursed on a ~~fee-for-service or~~ prepaid basis. ~~Prepaid~~ Provider service networks shall receive per-member, per-month payments. ~~A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.~~

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

~~(b)~~ A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

(a) A provider service network is exempt from parts I and III of chapter 641 but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency.

(b) This subsection does not authorize the agency to contract with a provider service network outside of the procurement process described in s. 409.966.

Section 2. *Section 409.9124, Florida Statutes, is repealed.*

Section 3. Section 409.964, Florida Statutes, is amended to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. ~~Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.~~

Section 4. Subsections (2), (3), and (4) of section 409.966, Florida Statutes, are amended to read:

409.966 Eligible plans; selection.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(1)(c). At least 90 days before issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data *consistent with actuarial rate-setting practices and standards* ~~for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region or county~~. The source of the data in the *databook* ~~report~~ must include*, at a minimum, the 24 most recent months of* ~~both historic fee-for-service claims and~~ validated data from the Medicaid Encounter Data System*, and the databook must*~~. The report must be available in electronic form and~~ delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score. *The statewide managed care program includes* ~~Separate and simultaneous procurements shall be conducted in each of~~ the following regions:

(a) Region *A* ~~1~~, which consists of *Bay, Calhoun,* Escambia*,* ~~Okaloosa, Santa Rosa, and Walton Counties.~~

~~(b) Region 2, which consists of Bay, Calhoun,~~ Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, *Okaloosa, Santa Rosa,* Taylor, Wakulla, *Walton,* and Washington Counties.

(b)~~(c)~~ Region *B* ~~3~~, which consists of Alachua, *Baker,* Bradford, Citrus, *Clay,* Columbia, Dixie, *Duval, Flagler,* Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, *Nassau,* Putnam, *St. Johns,* Sumter, Suwannee, ~~and~~ Union ~~Counties.~~

~~(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns~~, and Volusia Counties.

(c)~~(e)~~ Region *C* ~~5~~, which consists of Pasco and Pinellas Counties.

(d)~~(f)~~ Region *D* ~~6~~, which consists of Hardee, Highlands, Hillsborough, Manatee, and Polk Counties.

(e)~~(g)~~ Region *E* ~~7~~, which consists of Brevard, Orange, Osceola, and Seminole Counties.

(f)~~(h)~~ Region *F* ~~8~~, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties.

(g)~~(i)~~ Region *G* ~~9~~, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

(h)~~(j)~~ Region *H* ~~10~~, which consists of Broward County.

(i)~~(k)~~ Region *I* ~~11~~, which consists of Miami-Dade and Monroe Counties.

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that an eligible plan has *obtained signed contracts or* written agreements or ~~signed contracts or~~ has made substantial progress in establishing relationships with providers before the plan *submits* ~~submitting~~ a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

(b) An eligible plan must disclose any business relationship it has with any other eligible plan that responds to the invitation to negotiate. The agency may not select plans in the same region for the same managed care program that have a business relationship with each other. Failure to disclose any business relationship shall result in disqualification from participation in any region for the first full contract period after the discovery of the business relationship by the agency. For the purpose of this section, "business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, that exists for the purpose of making a profit.

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

1. Have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to s. 409.967(2)(c).

2. Have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan.

3. Are organizations that are based in and perform operational functions in this state, in-house or through contractual arrangements, by staff located in this state. Using a tiered approach, the highest number of points shall be awarded to a plan that has all or substantially all of its operational functions performed in the state. The second highest number of points shall be awarded to a plan that has a majority of its operational functions performed in the state. The agency may establish a third tier; however, preference points may not be awarded to plans that perform only community outreach, medical director functions, and state administrative functions in the state. For purposes of this subparagraph, operational functions include corporate headquarters, claims processing, member services, provider relations, utilization and prior authorization, case management, disease and quality functions, and finance and administration. For purposes of this subparagraph, the term "corporate headquarters" means the principal office of the organization, which may not be a subsidiary, directly or indirectly through one or more subsidiaries of, or a joint venture with, any other entity whose principal office is not located in the state.

4. Have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings.

6. Have a claims payment process that ensures that claims that are not contested or denied will be promptly paid pursuant to s. 641.3155.

~~(d) For the first year of the first contract term, the agency shall negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.~~

~~1. For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.~~

~~2. For provider service networks operating on a fee for service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee-for-service basis for the same services in the prior year.~~

~~(e) To ensure managed care plan participation in Regions 1 and 2, the agency shall award an additional contract to each plan with a contract award in Region 1 or Region 2. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency. If a plan that is awarded an additional contract pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(i) for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan must reimburse the agency for the cost of enrollment changes and other transition activities.~~

(d)~~(f)~~ The agency may not execute contracts with managed care plans at payment rates not supported by the General Appropriations Act.

(4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that participates in an invitation to negotiate ~~in more than one region and is selected in at least one region~~ may not begin serving Medicaid recipients ~~in any region for which it was selected~~ until all administrative challenges to procurements required by this section to which the eligible plan is a party have been finalized. If the number of plans selected is less than the maximum amount of plans permitted in the region, the agency may contract with other selected plans in the region not participating in the administrative challenge before resolution of the administrative challenge. For purposes of this subsection, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by

the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

Section 5. Paragraphs (c) and (f) of subsection (2) of section 409.967, Florida Statutes, are amended to read:

409.967 Managed care plan accountability.—

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

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. ~~A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge.~~ Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(f) *Continuous improvement.*—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

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

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under s. 409.977 and 409.984.

~~4. By the end of the fourth year of the first contract term, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring, including analysis of encounter data, assessment of performance measures, and compliance with other contractual requirements.~~

Section 6. Subsection (2) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(2) Provider service networks *must* ~~may~~ be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. ~~Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of its operation. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period must be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation is considered final.~~

Section 7. Subsections (3) and (4) of section 409.973, Florida Statutes, are amended to read:

409.973 Benefits.—

(3) HEALTHY BEHAVIORS.—Each plan operating in the managed medical assistance program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved *tobacco* ~~smoking~~ cessation program, a medically directed weight loss program, and a medically approved alcohol *recovery program* or substance abuse recovery program *that must include, but may not be limited to, opioid abuse recovery*. Each plan must identify enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participation in these programs.

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(a) Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider.

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an appointment with the primary care provider. If possible the appointment should be made within 30 days after enrollment in the plan. ~~For enrollees who become eligible for Medicaid between January 1, 2014, and December 31, 2015, the appointment should be scheduled within 6 months after enrollment in the plan.~~

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Section 8. Subsections (1) and (2) of section 409.974, Florida Statutes, are amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans *for the managed medical assistance program* through the procurement process described in s. 409.966 *through a single statewide procurement. The agency may award contracts to plans selected through the procurement process either on a regional or statewide basis. The awards must include at least one provider service network in each of the nine regions outlined in this subsection. The agency shall procure:*

(a) At least 3 plans and up to 4 plans for Region A.

(b) At least 3 plans and up to 6 plans for Region B.

(c) At least 3 plans and up to 5 plans for Region C.

(d) At least 4 plans and up to 7 plans for Region D.

(e) At least 3 plans and up to 6 plans for Region E.

(f) At least 3 plans and up to 4 plans for Region F.

(g) At least 3 plans and up to 5 plans for Region G.

(h) At least 3 plans and up to 5 plans for Region H.

(i) At least 5 plans and up to 10 plans for Region I. ~~The agency shall notice invitations to negotiate no later than January 1, 2013.~~

~~(a) The agency shall procure two plans for Region 1. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.~~

~~(b) The agency shall procure two plans for Region 2. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.~~

~~(c) The agency shall procure at least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(d) The agency shall procure at least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(e) The agency shall procure at least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(f) The agency shall procure at least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(g) The agency shall procure at least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(h) The agency shall procure at least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(i) The agency shall procure at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) The agency shall procure at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) The agency shall procure at least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in those regions where no provider service network has been selected.~~

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has *obtained signed contracts or* written agreements or ~~signed contracts or~~ has made substantial progress in establishing relationships with providers before the plan *submits* ~~submitting~~ a response. The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to s. 409.975(1). ~~The agency shall exercise a preference for plans with a provider network in which over 10 percent of the providers use electronic health records, as defined in s. 408.051.~~ When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

Section 9. Paragraph (b) of subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

5. Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v).

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals*, and payments to nonparticipating Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v),* shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 10. Subsections (1), (2), (4), and (5) of section 409.977, Florida Statutes, are amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. ~~In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available.~~ Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

(2) When automatically enrolling recipients in managed care plans, the agency shall automatically enroll based on the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipients.

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

(c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

(4) The agency shall develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage. ~~Contingent upon federal approval,~~ The agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under the Florida Health Choices Program, or any health exchange, to opt out. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient. The agency shall ~~seek federal approval to~~ require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

(5) Specialty plans serving children in the care and custody of the department may serve such children as long as they remain in care, including those remaining in extended foster care pursuant to s. 39.6251, or are in subsidized adoption and continue to be eligible for Medicaid pursuant to s. 409.903*, or are receiving guardianship assistance payments and continue to be eligible for Medicaid pursuant to s. 409.903*.

Section 11. Subsection (2) of section 409.981, Florida Statutes, is amended to read:

409.981 Eligible long-term care plans.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans *for the long-term care managed care program* through the procurement process described in s. 409.966 *through a single statewide procurement. The agency may award contracts to plans selected through the procurement process on a regional or statewide basis. The awards must include at least one provider service network in each of the nine regions outlined in this subsection*. The agency shall procure:

(a) *At least 3 plans and up to 4 plans for Region A.*

(b) At least 3 plans and up to 6 plans for Region B.

(c) At least 3 plans and up to 5 plans for Region C.

(d) At least 4 plans and up to 7 plans for Region D.

(e) At least 3 plans and up to 6 plans for Region E.

(f) At least 3 plans and up to 4 plans for Region F.

(g) At least 3 plans and up to 5 plans for Region G.

(h) At least 3 plans and up to 4 plans for Region H.

(i) At least 5 plans and up to 10 plans for Region I ~~Two plans for Region 1. At least one plan must be a provider service network if any provider service networks submit a responsive bid~~.

~~(b) Two plans for Region 2. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(c) At least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(d) At least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service network submits a responsive bid.~~

~~(e) At least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(f) At least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(g) At least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(h) At least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid in a region other than Region 1 or Region 2, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.~~

Section 12. Subsection (4) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.—

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

Section 13. For the purpose of incorporating the amendment made by this act to section 409.912, Florida Statutes, in references thereto, subsections (1), (7), (13), and (14) of section 409.962, Florida Statutes, are reenacted to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(1) "Accountable care organization" means an entity qualified as an accountable care organization in accordance with federal regulations, and which meets the requirements of a provider service network as described in s. 409.912(1).

(7) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(1) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

(13) "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(1), in the state and is paid a prospective per-member, per-month payment by the agency.

(14) "Provider service network" means an entity qualified pursuant to s. 409.912(1) of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

Section 14. For the purpose of incorporating the amendment made by this act to section 409.912, Florida Statutes, in a reference thereto, subsection (22) of section 641.19, Florida Statutes, is reenacted to read:

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

(22) "Provider service network" means a network authorized under s. 409.912(1), reimbursed on a prepaid basis, operated by a health care provider or group of affiliated health care providers, and which directly provides health care services under a Medicare, Medicaid, or Healthy Kids contract.

Section 15. For the purpose of incorporating the amendments made by this act to section 409.981, Florida Statutes, in references thereto, paragraphs (h), (i), and (j) of subsection (3) and subsection (11) of section 430.2053, Florida Statutes, are reenacted to read:

430.2053 Aging resource centers.—

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

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

(i) Provide enrollment and coverage information to Medicaid managed long-term care enrollees as qualified plans become available in each of the regions pursuant to s. 409.981(2).

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

(11) In an area in which the department has designated an area agency on aging as an aging resource center, the department and the agency shall not make payments for the services listed in subsection (9) and the Long-Term Care Community Diversion Project for such persons who were not screened and enrolled through the aging resource center. The department shall cease making payments for recipients in eligible plans as eligible plans become available in each of the regions defined in s. 409.981(2).

Section 16. *The Agency for Health Care Administration shall amend existing Statewide Medicaid Managed Care contracts to implement the changes made by this act to sections 409.973, 409.975, and 409.977, Florida Statutes. The agency shall implement the changes made by this act to sections 409.966, 409.974, and 409.981, Florida Statutes, for the 2025 plan year.*

Section 17. This act shall take effect July 1, 2022.

And the title is amended as follows:

Delete lines 992-1091 and insert: An act relating to the statewide Medicaid managed care program; amending s. 409.912, F.S.; requiring, rather than authorizing, that the reimbursement method for provider service networks be on a prepaid basis; deleting the authority to reimburse provider service networks on a fee-for-service basis; conforming provisions to changes made by the act; providing that provider service networks are subject to and exempt from certain requirements; providing construction; repealing s. 409.9124, F.S., relating to managed care reimbursement; amending s. 409.964, F.S.; deleting a requirement that the Agency for Health Care Administration provide the opportunity for public feedback on a certain waiver application; amending s. 409.966, F.S.; revising requirements relating to the databook published by the agency consisting of Medicaid utilization and spending data; reallocating regions within the statewide managed care program; deleting a requirement that the agency negotiate plan rates or payments to guarantee a certain savings amount; deleting a requirement for the agency to award additional contracts to plans in specified regions for certain purposes; revising a limitation on when plans may begin serving Medicaid recipients to apply to any eligible plan that participates in an invitation to negotiate, rather than plans participating in certain regions; making technical changes; amending s. 409.967, F.S.; deleting obsolete provisions; amending s. 409.968, F.S.; conforming provisions to changes made by the act; amending s. 409.973, F.S.; revising requirements for healthy behaviors programs established by plans; deleting an obsolete provision; amending s. 409.974, F.S.; requiring the agency to select plans for the managed medical assistance program through a single statewide procurement; authorizing the agency to award contracts to plans on a regional or statewide basis; specifying requirements for minimum numbers of plans which the agency must procure for each specified region; conforming provisions to changes made by the act; deleting procedures for plan procurements when no provider service networks submit bids; making technical changes; deleting a requirement for the agency to exercise a preference for certain plans; amending s. 409.975, F.S.; providing that cancer hospitals meeting certain criteria are statewide essential providers; requiring payments to such hospitals to equal a certain rate; amending s. 409.977, F.S.; deleting a requirement for maintaining a recipient's enrollment in a plan; deleting obsolete language; authorizing specialty plans to serve certain children who receive guardianship assistance payments under the Guardianship Assistance Program; amending s. 409.981, F.S.; requiring the agency to select plans for the long-term care managed medical assistance program through a single statewide procurement; authorizing the agency to award contracts to plans on a regional or statewide basis; specifying requirements for minimum numbers of plans which the agency must procure for each specified region; conforming provisions to changes made by the act; deleting procedures for plan procurements when no provider service networks submit bids; amending s. 409.8132, F.S.; conforming a cross-reference; reenacting ss. 409.962(1), (7), (13), and (14) and 641.19(22), F.S., relating to definitions, to incorporate the amendments made by this act to s. 409.912, F.S., in references thereto; reenacting s. 430.2053(3)(h), (i), and (j) and (11), F.S., relating to aging resource centers, to incorporate the amendments made by this act to s.

409.981, F.S., in references thereto; requiring the agency to amend existing Statewide Medicaid Managed Care contracts to implement changes made by the act; requiring the agency to implement changes made by the act for a specified plan year; providing an effective date.

On motion by Senator Brodeur, the Senate concurred in **House Amendment 1 (739505)**, as amended by **Senate Amendment 1 (967698)**, and requested the House to concur in the Senate amendment to the House amendment.

CS for CS for SB 1950 passed, as amended, and the action of the Senate was certified to the House. The vote on passage was:

Yeas—38

Mr. President	Cruz	Perry
Albritton	Diaz	Pizzo
Ausley	Farmer	Polsky
Baxley	Gainer	Powell
Bean	Garcia	Rodrigues
Berman	Gibson	Rodriguez
Book	Gruters	Rouson
Boyd	Harrell	Stargel
Bradley	Hooper	Stewart
Brandes	Hutson	Taddeo
Brodeur	Jones	Torres
Broxson	Mayfield	Wright
Burgess	Passidomo	

Nays—None

READING OF BILLS

CS for HB 7071—A bill to be entitled An act relating to taxation; creating s. 193.4613, F.S.; defining terms; providing for the assessment of land used in the production of aquaculture to be based solely on its agricultural use; providing assessment methodology; requiring property to be assessed for a certain period of time using a specified assessment methodology; authorizing the property appraiser to require audited financial statements; providing applicability; amending s. 194.032, F.S.; revising provisions to conform to changes made by the act; amending s. 196.173, F.S.; revising the military operations that qualify certain servicemembers for an additional ad valorem tax exemption; providing applicability; revising the deadlines for applying for additional ad valorem tax exemptions for certain servicemembers for a specified tax year; authorizing a property appraiser to grant a tax exemption for an untimely filed application if certain conditions are met; providing procedures for an applicant to file a petition with the value adjustment board if an application is denied; providing applicability; amending s. 196.1978, F.S.; revising the events which initiate the 15-year period for certain property to qualify for the affordable housing ad valorem tax exemption; providing applicability; amending s. 196.202, F.S.; increasing the property tax exemption for residents who are widows, widowers, blind persons, or totally and permanently disabled persons; providing applicability; creating s. 197.319, F.S.; defining terms; specifying conditions under which persons whose residential improvements are rendered uninhabitable may receive a refund of taxes originally levied and paid; specifying a formula for determining the amount of the tax refund; providing directives to property appraisers in issuing written statements to the tax collector when granting refunds; providing directives to tax collectors in calculating damage differentials and processing refunds; providing a mechanism for persons to file late applications for a refund of taxes; requiring tax collectors to provide specified information to the Department of Revenue and the governing boards of each affected local government annually; providing applicability; creating s. 197.3195, F.S.; defining the term "residential improvement"; providing for an abatement of ad valorem taxes and non-ad valorem assessments for certain residential improvements destroyed due to a sudden and unforeseen collapse; requiring property appraisers to provide specified statements to tax collectors; providing that owners of parcels meeting certain requirements are not required to remit payments; prohibiting property appraisers and tax collectors from issuing specified notices for parcels meeting certain requirements; requiring property appraisers to notify taxpayers of the abatement of taxes and non-ad valorem assessments under certain circumstances; requiring value adjustment boards to dismiss petitions under certain circumstances; specifying requirements for determining the assessed value of certain new homesteads; providing for a refund of taxes for parcels meeting certain requirements under certain circumstances; providing applicability; providing for future repeal; providing for retroactive application; amending 201.25, F.S.; exempting certain federal loans from documentary stamp taxes; amending s. 212.04, F.S.; exempting certain soccer matches held as part of a FIFA World Cup from the sales taxes on admissions; exempting certain Formula One Grand Prix race admissions from the sales tax on admissions; amending s. 212.05, F.S.; specifying the sales tax rate on new mobile homes; defining the term "new mobile home"; amending s. 212.08, F.S.; exempting from sales and use tax the sale of certain machinery and equipment that produce electric or steam energy from burning hydrogen; revising the total amount of community contribution tax credits which may be granted; defining the terms "green hydrogen" and "primarily used"; exempting from sales and use tax certain machinery and equipment involving green hydrogen, certain types of ammonia, and certain electrochemical reactions of green hydrogen and oxygen; providing guidelines for purchasers to use in obtaining an exemption; providing penalties; authorizing the department to adopt rules; amending s. 213.053, F.S.; authorizing the Department of Revenue to make certain information available to the Department of Transportation to administer the credit for qualified railroad reconstruction or replacement expenditures; amending s. 220.02, F.S.; specifying the method for applying certain railroad reconstruction or replacement expenditure credits against the corporate income tax or franchise tax; amending s. 220.03, F.S.; adopting the Internal Revenue Code in effect on January 1, 2022; providing an effective date; providing for retroactive operation; amending s. 220.13, F.S.; revising the definition of the term "adjusted federal income" to adjust for certain railroad reconstruction or replacement expenditure credits; amending s. 220.183, F.S.; revising the total amount of community contribution tax credits which may be granted; amending s. 220.1876, F.S.; revising backward by 1 year the taxable years for which the New Worlds Reading Initiative credits are authorized; amending s. 220.1877, F.S.; revising backward by 1 year the taxable years for which credits for contributions to eligible charitable organizations are authorized; creating s. 220.1915, F.S.; defining terms related to expenditures for railroad reconstruction and replacement; providing a specified tax credit for qualifying railroads against the corporate income tax if specified criteria are met; providing procedures for receiving such tax credit; authorizing the carryforward of such tax credit; authorizing the department to adopt rules; amending s. 402.62, F.S.; increasing the Strong Families tax credit cap; amending s. 624.5105, F.S.; revising the total amount of community contribution tax credits which may be granted; amending s. 624.51056, F.S.; revising backward by 1 year the taxable years for which the New Worlds Reading Initiative tax credits are authorized; amending s. 624.51057, F.S.; revising backward by 1 year the taxable years for which Strong Families tax credits for contributions to eligible charitable organizations are authorized; amending s. 1003.485, F.S.; increasing the allowable carryforward of unused eligible contributions from one state fiscal year to the next for the New Worlds Reading Initiative; providing legislative intent; providing for a retroactive refund of certain taxes paid; specifying the treatment of specified contributions under the Strong Families tax credit program and the New Worlds Reading Initiative tax credit program for a specified year; providing directives for receiving a refund of previously paid taxes; prohibiting such refund from exceeding a specified amount; providing a carryforward period; prohibiting refund payments after a specified date; authorizing the department to adopt emergency rules related to the Strong Families tax credit program and the New Worlds Reading Initiative tax credit program; providing for retroactive operation; exempting from sales and use tax the retail sale of certain clothing, wallets, bags, school supplies, learning aids and jigsaw puzzles, and personal computers and personal computer-related accessories during a specified timeframe; defining terms; specifying locations where the tax exemptions do not apply; authorizing certain dealers to opt out of participating in the tax holiday, subject to certain requirements; authorizing the department to adopt emergency rules; exempting from sales and use tax specified disaster preparedness supplies during a specified timeframe; defining terms; specifying locations where the tax exemptions do not apply; authorizing the department to adopt emergency rules; exempting from sales and use tax admissions to certain events, performances, and facilities during specified timeframes, certain season tickets, and the retail sale of certain boating and water activity, camping, fishing, general outdoor, and residential pool supplies and sporting equipment during specified timeframes; defining terms; specifying locations where the exemptions do not apply; authorizing the department to adopt emergency rules; exempting from the sales and use tax the retail sale of tools used by skilled trade workers during a specified timeframe; authorizing the department to adopt emergency rules; exempting from sales and use tax the retail sale of children's books during a specified timeframe; defining terms; authorizing the department to adopt emergency rules; exempting from sales and use tax the retail sale of new ENERGY STAR ap-

pliances during a specified timeframe; defining a term; exempting from sales and use tax the retail sale of children's diapers during a specified timeframe; exempting from sales and use tax the retail sale of baby and toddler clothing during a specified timeframe; exempting from sales and use tax the retail sale of impact-resistant windows, impact-resistant doors, and impact-resistant garage doors during a specified timeframe; authorizing the department to adopt emergency rules; providing effective dates.

—was read the second time by title, and, by two-thirds vote, **CS for HB 7071** was read the third time by title.

CS for HB 7071 was placed in the Budget Conference on March 9.

MESSAGES FROM THE HOUSE OF REPRESENTATIVES

RETURNING MESSAGES — FINAL ACTION

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has concurred in Senate amendment 1 (967698) to House amendment 1 (739505) and passed CS/CS/SB 1950 as further amended.

Jeff Takacs, Clerk

The bill contained in the foregoing message was ordered engrossed and then enrolled.

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has adopted SCR 2002 by the required constitutional three-fifths vote of the membership voting.

Jeff Takacs, Clerk

The bill contained in the foregoing message was ordered enrolled.

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has concurred in Senate amendment 1 (880670) and passed CS/HB 3, as amended.

Jeff Takacs, Clerk

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has concurred in Senate amendments 1 (892588) and 3 (721266) and passed CS/CS/HB 921, as amended.

Jeff Takacs, Clerk

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has concurred in Senate amendment 1 (430624) and passed CS/CS/HB 963, as amended.

Jeff Takacs, Clerk

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has concurred in Senate amendment 1 (136796) and passed CS/HB 1209, as amended.

Jeff Takacs, Clerk

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has concurred in Senate amendment 1 (745288) and passed CS/HB 1467, as amended.

Jeff Takacs, Clerk

The Honorable Wilton Simpson, President

I am directed to inform the Senate that the House of Representatives has concurred in Senate amendment 5 (388396) and passed CS/HB 7049, as amended.

Jeff Takacs, Clerk

ENROLLING REPORTS

SCR 2002 has been enrolled, signed by the required constitutional officers, and filed with the Secretary of State on March 11, 2022.

Debbie Brown, Secretary

CORRECTION AND APPROVAL OF JOURNAL

The Journal of March 10 was corrected and approved.

CO-INTRODUCERS

Senator Perry—CS for SB 896

ADJOURNMENT

On motion by Senator Passidomo, the Senate adjourned at 2:19 p.m. for the purpose of holding committee meetings and conducting other Senate business to reconvene at 12:00 noon, Monday, March 14 or upon call of the President.