

COMMITTEE MEETING EXPANDED AGENDA

**BUDGET SUBCOMMITTEE ON HEALTH AND HUMAN
SERVICES APPROPRIATIONS**

Senator Negrón, Chair
Senator Rich, Vice Chair

MEETING DATE: Thursday, February 17, 2011

TIME: 8:00 —10:15 a.m.

PLACE: *Toni Jennings Committee Room, 110 Senate Office Building*

MEMBERS: Senator Negrón, Chair; Senator Rich, Vice Chair; Senators Gaetz, Garcia, Oelrich, Richter, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Budget Work Session		
2	Discussion on Medicaid Reform Discussion of Draft Legislation		

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1 A bill to be entitled
2 An act relating to health and human services; amending
3 s. 216.262, F.S.; providing that limitations on an
4 agency's total number of positions does not apply to
5 certain positions in the Department of Health;
6 amending s. 393.063, F.S.; redefining the term
7 "developmental disability" to include Down syndrome;
8 defining the term "Down syndrome" as it relates to
9 developmental disabilities; amending s. 393.0661,
10 F.S.; conforming provisions to changes made by the
11 act; amending s. 408.7057, F.S.; requiring that the
12 dispute resolution program include a hearing in
13 specified circumstances; providing that the dispute
14 resolution program established to resolve claims
15 disputes between providers and health plans does not
16 provide an independent right of recovery; requiring
17 that the conclusions of law in the written
18 recommendation of the resolution organization identify
19 certain information; providing a directive to the
20 Division of Statutory Revision; amending s. 409.016,
21 F.S.; conforming provisions to changes made by the
22 act; creating s. 409.16713, F.S.; providing for
23 medical assistance for children in out-of-home care
24 and adopted children; specifying how those services
25 will be funded under certain circumstances; providing
26 legislative intent; providing a directive to the
27 Division of Statutory Revision; transferring,
28 renumbering, and amending s. 624.91, F.S.; decreasing
29 the administrative cost and raising the minimum loss

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30 ratio for health plans; increasing compensation to the
31 insurer or provider for dental contracts; requiring
32 the Florida Healthy Kids Corporation to include use of
33 the school breakfast and lunch application form in the
34 corporation's plan for publicizing the program;
35 conforming provisions to changes made by the act;
36 amending ss. 409.813, 409.8132, 409.815, 409.818,
37 154.503, and 408.915, F.S.; conforming provisions to
38 changes made by the act; amending s. 1006.06, F.S.;
39 requiring school districts to collaborate with the
40 Florida Kidcare program to use the application form
41 for the school breakfast and lunch programs to provide
42 information about the Florida Kidcare program and to
43 authorize data on the application form be shared with
44 state agencies and the Florida Healthy Kids
45 Corporation and its agents; authorizing each school
46 district the option to share the data electronically;
47 requiring interagency agreements to ensure that the
48 data exchanged is protected from unauthorized
49 disclosure and is used only for enrollment in the
50 Florida Kidcare program; amending s. 409.901, F.S.;
51 revising definitions relating to Medicaid; amending s.
52 409.902, F.S.; revising provisions relating to the
53 designation of the Agency for Health Care
54 Administration as the state Medicaid agency;
55 specifying that eligibility and state funds for
56 medical services apply only to citizens and certain
57 noncitizens; providing exceptions; providing a
58 limitation on persons transferring assets in order to

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59 become eligible for Medicaid nursing facility
60 services; amending s. 409.9021, F.S.; revising
61 provisions relating to conditions for Medicaid
62 eligibility; increasing the number of years a Medicaid
63 applicant forfeits entitlements to the Medicaid
64 program if he or she has committed fraud; providing
65 for the payment of monthly premiums by Medicaid
66 recipients; providing exemptions to the premium
67 requirement; requiring applicants to agree to
68 participate in certain health programs; prohibiting a
69 recipient who has access to employer-sponsored health
70 care from obtaining services reimbursed through the
71 Medicaid fee-for-service system; requiring the agency
72 to develop a process to allow the Medicaid premium
73 that would have been received to be used to pay
74 employer premiums; requiring that the agency allow
75 opt-out opportunities for certain recipients; creating
76 s. 409.9022, F.S.; specifying procedures to be
77 implemented by a state agency if the Medicaid
78 expenditures exceed appropriations; amending s.
79 409.903, F.S.; conforming provisions to changes made
80 by the act; deleting obsolete provisions; amending s.
81 409.904, F.S.; conforming provisions to changes made
82 by the act; renaming the "medically needy" program as
83 the "Medicaid nonpoverty medical subsidy"; narrowing
84 the subsidy to cover only certain services for a
85 family, persons age 65 or older, or blind or disabled
86 persons; revising the criteria for the agency's
87 assessment of need for private duty nursing services;

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88 amending s. 409.905, F.S.; conforming provisions to
89 changes made by the act; requiring prior authorization
90 for home health services; amending s. 409.906, F.S.;
91 providing for a parental fee based on family income to
92 be assessed against the parents of children with
93 developmental disabilities served by home and
94 community-based waivers; prohibiting the agency from
95 paying for certain psychotropic medications prescribed
96 for a child; conforming provisions to changes made by
97 the act; amending ss. 409.9062 and 409.907, F.S.;
98 conforming provisions to changes made by the act;
99 amending s. 409.908, F.S.; modifying the nursing home
100 patient care per diem rate to include dental care and
101 podiatric care; directing the agency to seek a waiver
102 to treat a portion of the nursing home per diem as
103 capital for self-insurance purposes; requiring primary
104 physicians to be paid the Medicare fee-for-service
105 rate by a certain date; deleting the requirement that
106 the agency contract for transportation services with
107 the community transportation system; authorizing
108 qualified plans to contract for transportation
109 services; deleting obsolete provisions; conforming
110 provisions to changes made by the act; amending s.
111 409.9081, F.S.; revising copayments for physician
112 visits; requiring the agency to seek a waiver to allow
113 the increase of copayments for nonemergency services
114 furnished in a hospital emergency department; amending
115 s. 409.912, F.S.; requiring Medicaid-eligible children
116 who have open child welfare cases who reside in AHCA

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117 area 10 to be enrolled in specified capitated managed
118 care plans; expanding the number of children eligible
119 to receive behavioral health care services through a
120 specialty prepaid plan; repealing provisions relating
121 to a provider lock-in program; eliminating obsolete
122 provisions and updating provisions; conforming cross-
123 references; amending s. 409.915, F.S.; conforming
124 provisions to changes made by the act; transferring,
125 renumbering, and amending s. 409.9301, F.S.;
126 conforming provisions to changes made by the act;
127 amending s. 409.9126, F.S.; conforming a cross-
128 reference; providing a directive to the Division of
129 Statutory Revision; creating s. 409.961, F.S.;
130 providing for statutory construction of provisions
131 relating to Medicaid managed care; creating s.
132 409.962, F.S.; providing definitions; creating s.
133 409.963, F.S.; establishing the Medicaid managed care
134 program as the statewide, integrated managed care
135 program for medical assistance and long-term care
136 services; directing the agency to apply for and
137 implement waivers; providing for public notice and
138 comment; providing for a limited managed care program
139 if waivers are not approved; creating s. 409.964,
140 F.S.; requiring all Medicaid recipients to be enrolled
141 in Medicaid managed care; providing exemptions;
142 prohibiting a recipient who has access to employer-
143 sponsored health care from enrolling in Medicaid
144 managed care; requiring the agency to develop a
145 process to allow the Medicaid premium that would have

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146 been received to be used to pay employer premiums;
147 requiring that the agency allow opt-out opportunities
148 for certain recipients; providing for voluntary
149 enrollment; creating s. 409.965, F.S.; providing
150 requirements for qualified plans that provide services
151 in the Medicaid managed care program; requiring the
152 agency to issue an invitation to negotiate; requiring
153 the agency to compile and publish certain information;
154 establishing regions for separate procurement of
155 plans; establishing selection criteria for plan
156 selection; limiting the number of plans in a region;
157 authorizing the agency to conduct negotiations if
158 funding is insufficient; providing that the Children's
159 Medical Service Network is a qualified plan; creating
160 s. 409.966, F.S.; providing managed care plan contract
161 requirements; establishing contract terms; providing
162 for annual rate setting; providing for contract
163 extension under certain circumstances; establishing
164 access requirements; requiring the agency to
165 establishing performance standards for plans;
166 providing for program integrity; requiring plans to
167 provide encounter data; providing penalties for
168 failure to submit data; requiring plans to accept
169 electronic claims; providing for prompt payment;
170 providing for payments to noncontract emergency
171 providers; requiring a surety bond; requiring plans to
172 establish a grievance resolution process; requiring
173 plan solvency; requiring guaranteed savings; providing
174 costs and penalties for early termination of contracts

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175 or reduction in enrollment levels; requiring the
176 agency to terminate qualified plans for noncompliance
177 under certain circumstances; creating s. 409.967,
178 F.S.; providing for managed care plan accountability;
179 establishing a medical loss ratio; requiring that a
180 plan pay back to the agency a specified amount in
181 specified circumstances; authorizing plans to limit
182 providers in networks; mandating that certain
183 providers be offered contracts during the first year;
184 authorizing plans to exclude certain providers in
185 certain circumstances; requiring plans to monitor the
186 quality and performance history of providers;
187 requiring plans to hold primary care physicians
188 responsible for certain activities; requiring plans to
189 offer certain programs and procedures; requiring plans
190 to pay primary care providers the same rate as
191 Medicare by a certain date; providing for conflict
192 resolution between plans and providers; creating s.
193 409.968, F.S.; providing for managed care plan
194 payments on a per-member, per-month basis; requiring
195 the agency to establish a methodology to ensure the
196 availability of certain types of payments to specified
197 providers; requiring the development of rate cells;
198 requiring that the amount paid to the plans for
199 supplemental payments or enhanced rates be reconciled
200 to the amount required to pay providers; requiring
201 that plans make certain payments to providers within a
202 certain time; creating s. 409.969, F.S.; authorizing
203 Medicaid recipients to select any plan within a

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204 region; providing for automatic enrollment of
205 recipients by the agency; providing criteria for
206 automatic enrollment; authorizing disenrollment under
207 certain circumstances; providing for a grievance
208 process; defining the term "good cause" for purposes
209 of disenrollment; requiring recipients to stay in
210 plans for a specified time; providing for reenrollment
211 of recipients who move out of a region; creating s.
212 409.970, F.S.; requiring the agency to maintain an
213 encounter data system; providing requirements for
214 prepaid plans to submit data in a certain format;
215 requiring the agency to analyze the data; requiring
216 the agency to test the data for certain purposes by a
217 certain date; creating s. 409.971, F.S.; providing for
218 managed care medical assistance; providing deadlines
219 for beginning and finalizing implementation; creating
220 s. 409.972, F.S.; establishing minimum services for
221 the managed medical assistance; providing for optional
222 services; authorizing plans to customize benefit
223 packages; creating s. 409.973, F.S.; providing for
224 managed long-term care; providing deadlines for
225 beginning and finalizing implementation; providing
226 duties for the Department of Elderly Affairs relating
227 to the program; creating s. 409.974, F.S.; providing
228 recipient eligibility requirements for managed long-
229 term care; listing programs for which certain
230 recipients are eligible; specifying that an
231 entitlement to home and community-based services is
232 not created; creating s. 409.975, F.S.; establishing

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233 minimum services for managed long-term care; creating
234 s. 409.976, F.S.; providing criteria for the selection
235 of plans to provide managed long-term care; creating
236 s. 409.977, F.S.; providing for managed long-term care
237 plan accountability; requiring the agency to establish
238 and plans to comply with standards for specified
239 providers; creating s. 409.978, F.S.; requiring that
240 the agency operate the Comprehensive Assessment and
241 Review for Long-Term Care Services program through an
242 interagency agreement with the Department of Elderly
243 Affairs; providing duties of the program; requiring
244 the program to assign plan enrollees to a level of
245 care; providing for the evaluation of dually eligible
246 nursing home residents; transferring, renumbering, and
247 amending ss. 409.91207, 409.91211, 409.9122, F.S.;
248 conforming provisions to changes made by the act;
249 updating provisions and deleting obsolete provisions;
250 transferring and renumbering ss. 409.9123 and
251 409.9124, F.S.; amending s. 430.04, F.S.; eliminating
252 outdated provisions; requiring the Department of
253 Elderly Affairs to develop a transition plan for
254 specified elders and disabled adults receiving long-
255 term care Medicaid services if qualified plans become
256 available; amending s. 430.2053, F.S.; eliminating
257 outdated provisions; providing additional duties of
258 aging resource centers; providing an additional
259 exception to direct services that may not be provided
260 by an aging resource center; providing for the
261 cessation of specified payments by the department as

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262 qualified plans become available; eliminating
263 provisions requiring reports; amending s. 39.407,
264 F.S.; requiring a motion by the Department of Children
265 and Family Services to provide psychotropic medication
266 to a child 10 years of age or younger to include a
267 review by a child psychiatrist; providing that a court
268 may not authorize the administration of such
269 medication absent a finding of compelling state
270 interest based on the review; amending s. 400.023,
271 F.S.; requiring the trial judge to conduct an
272 evidentiary hearing to determine the sufficiency of
273 evidence for claims against certain persons relating
274 to a nursing home; limiting noneconomic damages in a
275 wrongful death action against the nursing home;
276 amending s. 400.0237, F.S.; revising provisions
277 relating to punitive damages against a nursing home;
278 authorizing a defendant to proffer admissible evidence
279 to refute a claimant's proffer of evidence for
280 punitive damages; requiring the trial judge to conduct
281 an evidentiary hearing and the plaintiff to
282 demonstrate that a reasonable basis exists for the
283 recovery of punitive damages; prohibiting discovery of
284 the defendant's financial worth until the judge
285 approves the pleading on punitive damages; revising
286 definitions; amending s. 409.1671, F.S.; modifying the
287 amount and limits of general liability coverage,
288 automobile coverage, and tort coverage that must be
289 carried by eligible community lead agency providers
290 and their subcontractors; providing that the

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291 Department of Children and Family Services is not
292 liable for the acts or omissions of such lead agencies
293 and that the agencies may not be required to indemnify
294 the department; creating ss. 458.3167 and 459.0078,
295 F.S.; providing for an expert witness certificate for
296 allopathic and osteopathic physicians licensed in
297 other states or Canada which authorizes such
298 physicians to provide expert medical opinions in this
299 state; providing application requirements and
300 timeframes for approval or denial by the Board of
301 Medicine and Board of Osteopathic Medicine,
302 respectively; requiring the boards to adopt rules and
303 set fees; providing for expiration of a certificate;
304 amending ss. 458.331 and 459.015, F.S.; providing
305 grounds for disciplinary action for providing
306 misleading, deceptive, or fraudulent expert witness
307 testimony relating to the practice of medicine and of
308 osteopathic medicine, respectively; providing for
309 construction with respect to the doctrine of
310 incorporation by reference; amending s. 766.102, F.S.;
311 providing that a physician who is an expert witness in
312 a medical malpractice presuit action must meet certain
313 requirements; amending s. 766.104, F.S.; requiring a
314 good faith demonstration in a medical malpractice case
315 that there has been a breach of the standard of care;
316 amending s. 766.106, F.S.; clarifying that a physician
317 acting as an expert witness is subject to disciplinary
318 actions; amending s. 766.1115, F.S.; conforming
319 provisions to changes made by the act; creating s.

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320 766.1183, F.S.; defining terms; providing for the
321 recovery of civil damages by Medicaid recipients
322 according to a modified standard of care; providing
323 for recovery of certain excess judgments by act of the
324 Legislature; requiring the Department of Children and
325 Family Services to provide notice to program
326 applicants; creating s. 766.1184, F.S.; defining
327 terms; providing for the recovery of civil damages by
328 certain recipients of primary care services at primary
329 care clinics receiving specified low-income pool funds
330 according to a modified standard of care; providing
331 for recovery of certain excess judgments by act of the
332 Legislature; providing requirements of health care
333 providers receiving such funds in order for the
334 liability provisions to apply; requiring notice to
335 low-income pool recipients; amending s. 766.203, F.S.;
336 requiring the presuit investigations conducted by the
337 claimant and the prospective defendant in a medical
338 malpractice action to provide grounds for a breach of
339 the standard of care; amending s. 768.28, F.S.;
340 revising a definition; providing that colleges and
341 universities that own or operate an accredited medical
342 school and their employees and agents providing
343 patient services in a public teaching hospital
344 pursuant to an affiliation agreement or contract with
345 the teaching hospital are considered agents of the
346 hospital for the purposes of the applicability of
347 sovereign immunity; providing definitions; requiring
348 patients of such hospitals to be provided with notice

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349 of their remedies under sovereign immunity; providing
350 legislative findings and intent with respect to
351 including colleges and universities and their
352 employees and agents under sovereign immunity;
353 providing a statement of public necessity; amending s.
354 1004.41, F.S.; clarifying provisions relating to
355 references to the corporation known as Shands Teaching
356 Hospital and Clinics, Inc.; clarifying provisions
357 regarding the purpose of the corporation; authorizing
358 the corporation to create corporate subsidiaries and
359 affiliates; providing that Shands Teaching Hospital
360 and Clinics, Inc., Shands Jacksonville Medical Center,
361 Inc., Shands Jacksonville Healthcare, Inc., and any
362 not-for-profit subsidiary of such entities are
363 instrumentalities of the state for purposes of
364 sovereign immunity; repealing s. 409.9121, F.S.,
365 relating to legislative intent concerning managed
366 care; repealing s. 409.919, F.S., relating to rule
367 authority; repealing s. 624.915, F.S., relating to the
368 Florida Healthy Kids Corporation operating fund;
369 renumbering and transferring ss. 409.942, 409.944,
370 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.
371 414.29, 163.464, 163.465, 163.466, 402.81, and 402.82,
372 F.S., respectively; amending s. 443.111, F.S.;
373 conforming a cross-reference; directing the Agency for
374 Health Care Administration to submit a reorganization
375 plan to the Legislature; providing for the state's
376 withdrawal from the Medicaid program under certain
377 circumstances; providing for severability; providing

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378 an effective date.

379

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

381

382 Section 1. Paragraph (a) of subsection (1) of section
383 216.262, Florida Statutes, is amended to read:

384 216.262 Authorized positions.—

385 (1) (a) Except as ~~Unless~~ otherwise ~~expressly~~ provided by
386 law, the total number of authorized positions may not exceed the
387 total provided in the appropriations acts. If a ~~In the event any~~
388 state agency or entity of the judicial branch finds that the
389 number of positions so provided is not sufficient to administer
390 its authorized programs, it may file an application with the
391 Executive Office of the Governor or the Chief Justice~~r~~ and, if
392 the Executive Office of the Governor or Chief Justice certifies
393 that there are no authorized positions available for addition,
394 deletion, or transfer within the agency or entity as provided in
395 paragraph (c), may recommend ~~and recommends~~ an increase in the
396 number of positions.r

397 1. The Governor or the Chief Justice may recommend an
398 increase in the number of positions for the following reasons
399 only:

400 a.1. ~~To~~ implement or provide for continuing federal grants
401 or changes in grants not previously anticipated.

402 b.2. ~~To~~ meet emergencies pursuant to s. 252.36.

403 c.3. ~~To~~ satisfy new federal regulations or changes therein.

404 d.4. ~~To~~ take advantage of opportunities to reduce operating
405 expenditures or to increase the revenues of the state or local
406 government.

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407 ~~e.5.~~ To authorize positions that were not fixed by the
408 Legislature due to ~~through~~ error in drafting the appropriations
409 acts.

410 2. Actions recommended pursuant to this paragraph are
411 subject to approval by the Legislative Budget Commission. The
412 certification and the final authorization shall be provided to
413 the Legislative Budget Commission, the legislative
414 appropriations committees, and the Auditor General.

415 3. The provisions of this paragraph do not apply to
416 positions in the Department of Health which are funded by the
417 County Health Department Trust Fund.

418 Section 2. Subsection (9) of section 393.063, Florida
419 Statutes, is amended, present subsections (13) through (40) of
420 that section are redesignated as subsections (14) through (41),
421 respectively, and a new subsection (13) is added to that
422 section, to read:

423 393.063 Definitions.—For the purposes of this chapter, the
424 term:

425 (9) "Developmental disability" means a disorder or syndrome
426 that is attributable to retardation, cerebral palsy, autism,
427 spina bifida, Down syndrome, or Prader-Willi syndrome; that
428 manifests before the age of 18; and that constitutes a
429 substantial handicap that can reasonably be expected to continue
430 indefinitely.

431 (13) "Down syndrome" means a disorder that is caused by the
432 presence of an extra chromosome 21.

433 Section 3. Present subsections (7) and (8) of section
434 393.0661, Florida Statutes, are redesignated as subsections (8)
435 and (9), respectively, a new subsection (7) is added to that

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436 section, and present subsection (7) of that section is amended,
437 to read:

438 393.0661 Home and community-based services delivery system;
439 comprehensive redesign.—The Legislature finds that the home and
440 community-based services delivery system for persons with
441 developmental disabilities and the availability of appropriated
442 funds are two of the critical elements in making services
443 available. Therefore, it is the intent of the Legislature that
444 the Agency for Persons with Disabilities shall develop and
445 implement a comprehensive redesign of the system.

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

449 (8) ~~(7) Nothing in~~ This section or related in any
450 administrative rule does not shall be construed to prevent or
451 limit the Agency for Health Care Administration, in consultation
452 with the Agency for Persons with Disabilities, from adjusting
453 fees, reimbursement rates, lengths of stay, number of visits, or
454 number of services, or from limiting enrollment, or making any
455 other adjustment necessary to comply with the availability of
456 moneys and any limitations or directions provided ~~for~~ in the
457 General Appropriations Act or pursuant to s. 409.9022.

458 Section 4. Subsections (3) and (4) of section 408.7057,
459 Florida Statutes, are amended, subsection (7) of that section is
460 redesignated as subsection (8), and a new subsection (7) is
461 added to that section, to read:

462 408.7057 Statewide provider and health plan claim dispute
463 resolution program.—

464 (3) The agency shall adopt rules to establish a process to

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465 be used by the resolution organization in considering claim
466 disputes submitted by a provider or health plan which must
467 include a hearing, if requested by the respondent, and the
468 issuance by the resolution organization of a written
469 recommendation, supported by findings of fact and conclusions of
470 law, to the agency within 60 days after the requested
471 information is received by the resolution organization within
472 the timeframes specified by the resolution organization. ~~In no~~
473 ~~event shall~~ The review time may not exceed 90 days following
474 receipt of the initial claim dispute submission by the
475 resolution organization.

476 (4) Within 30 days after receipt of the recommendation of
477 the resolution organization, the agency shall adopt the
478 recommendation as a final order subject to chapter 120.

479 (7) This section creates a procedure for dispute resolution
480 and not an independent right of recovery. The conclusions of law
481 contained in the written recommendation of the resolution
482 organization must identify the provisions of law or contract
483 which, under the particular facts and circumstances of the case,
484 entitle the provider or health plan to the amount awarded, if
485 any.

486 Section 5. The Division of Statutory Revision is requested
487 to designate ss. 409.016-409.803, Florida Statutes, as part I of
488 chapter 409, Florida Statutes, entitled "SOCIAL AND ECONOMIC
489 ASSISTANCE."

490 Section 6. Section 409.016, Florida Statutes, is amended to
491 read:

492 409.016 Definitions.—As used in this part, the term
493 chapter:

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

496 (2) "Secretary" means the Secretary of ~~the Department of~~
497 Children and Family Services.

498 (3) "Social and economic services," ~~within the meaning of~~
499 ~~this chapter,~~ means the providing of financial assistance as
500 well as preventive and rehabilitative social services for
501 children, adults, and families.

502 Section 7. Section 409.16713, Florida Statutes, is created
503 to read:

504 409.16713 Medical assistance for children in out-of-home
505 care and adopted children.-

506 (1) A child who is eligible under Title IV-E of the Social
507 Security Act, as amended, for subsidized board payments, foster
508 care, or adoption subsidies, and a child for whom the state has
509 assumed temporary or permanent responsibility and who does not
510 qualify for Title IV-E assistance but is in foster care, shelter
511 or emergency shelter care, or subsidized adoption is eligible
512 for medical assistance as provided in s. 409.903(4). This
513 includes a young adult who is eligible to receive services under
514 s. 409.1451(5) until the young adult reaches 21 years of age,
515 and a person who was eligible, as a child, under Title IV-E for
516 foster care or the state-provided foster care and who is a
517 participant in the Road-to-Independence Program.

518 (2) If medical assistance under Title XIX of the Social
519 Security Act, as amended, is not available due to the refusal of
520 the federal Department of Health and Human Services to provide
521 federal funds, a child or young adult described in subsection
522 (1) is eligible for medical services under the Medicaid managed

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523 care program established in s. 409.963. Such medical assistance
524 shall be obtained by the community-based care lead agencies
525 established under s. 409.1671 and is subject to the availability
526 of funds appropriated for such purpose in the General
527 Appropriations Act.

528 (3) It is the intent of the Legislature that the provision
529 of medical assistance meet the requirements of s. 471(a)(21) of
530 the Social Security Act, as amended, 42 U.S.C. s. 671(a)(21),
531 related to eligibility for Title IV-E of the Social Security
532 Act, and that compliance with such provisions meet the
533 requirements of s. 402(a)(3) of the Social Security Act, as
534 amended, 42 U.S.C. s. 602(a)(3), relating to the Temporary
535 Assistance for Needy Families Block Grant Program.

536 Section 8. The Division of Statutory Revision is requested
537 to designate ss. 409.810-409.821, Florida Statutes, as part II
538 of chapter 409, Florida Statutes, entitled "KIDCARE."

539 Section 9. Section 624.91, Florida Statutes, is
540 transferred, renumbered as section 409.8115, Florida Statutes,
541 paragraph (b) of subsection (5) of that section is amended, and
542 subsection (8) is added to that section, to read:

543 409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.-

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

545 (b) The Florida Healthy Kids Corporation shall:

546 1. Arrange for the collection of any family, local
547 contributions, or employer payment or premium, in an amount to
548 be determined by the board of directors, to provide for payment
549 of premiums for comprehensive insurance coverage and for the
550 actual or estimated administrative expenses.

551 2. Arrange for the collection of any voluntary

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552 contributions ~~to provide~~ for payment of Florida Kidcare program
553 premiums for children who are not eligible for medical
554 assistance under Title XIX or Title XXI of the Social Security
555 Act.

556 3. Subject to ~~the provisions of~~ s. 409.8134, accept
557 voluntary supplemental local match contributions that comply
558 with ~~the requirements of~~ Title XXI of the Social Security Act
559 for the purpose of providing additional Florida Kidcare coverage
560 in contributing counties under Title XXI.

561 4. Establish the administrative and accounting procedures
562 for the operation of the corporation.

563 5. Establish, with consultation from appropriate
564 professional organizations, standards for preventive health
565 services and providers and comprehensive insurance benefits
566 appropriate to children if, provided that such standards for
567 rural areas do ~~shall~~ not limit primary care providers to board-
568 certified pediatricians.

569 6. Determine eligibility for children seeking to
570 participate in the Title XXI-funded components of the Florida
571 Kidcare program consistent with the requirements specified in s.
572 409.814, as well as the non-Title-XXI-eligible children as
573 provided in subsection (3).

574 7. Establish procedures under which providers of local
575 match to, applicants to, and participants in the program may
576 have grievances reviewed by an impartial body and reported to
577 the board of directors of the corporation.

578 8. Establish participation criteria and, if appropriate,
579 contract with an authorized insurer, health maintenance
580 organization, or third-party administrator to provide

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581 administrative services to the corporation.

582 9. Establish enrollment criteria that include penalties or
583 30-day waiting periods ~~of 30 days~~ for reinstatement of coverage
584 upon voluntary cancellation for nonpayment of family premiums.

585 10. Contract with authorized insurers or providers ~~any~~
586 ~~provider~~ of health care services, who meet ~~meeting~~ standards
587 established by the corporation, for the provision of
588 comprehensive insurance coverage to participants. Such standards
589 must ~~shall~~ include criteria under which the corporation may
590 contract with more than one provider of health care services in
591 program sites. Health plans shall be selected through a
592 competitive bid process. The Florida Healthy Kids Corporation
593 shall purchase goods and services in the most cost-effective
594 manner consistent with the delivery of quality medical care. The
595 maximum administrative cost for a Florida Healthy Kids
596 Corporation contract shall be 10 ~~15~~ percent. For health care
597 contracts, the minimum medical loss ratio for a Florida Healthy
598 Kids Corporation contract shall be 90 ~~85~~ percent. For dental
599 contracts, the remaining compensation to be paid to the
600 authorized insurer or provider must be at least 90 ~~under a~~
601 ~~Florida Healthy Kids Corporation contract shall be no less than~~
602 ~~an amount which is 85 percent of the premium, and,~~ to the extent
603 any contract provision does not provide for this minimum
604 compensation, this section prevails ~~shall prevail~~. The health
605 plan selection criteria and scoring system, and the scoring
606 results, shall be available upon request for inspection after
607 the bids have been awarded.

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

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610 12. Develop and implement a plan to publicize the Florida
611 Kidcare program, the eligibility requirements of the program,
612 and the procedures for enrollment in the program and to maintain
613 public awareness of the corporation and the program. Such plan
614 must include using the application form for the school lunch and
615 breakfast programs as provided under s. 1006.06(7).

616 13. Secure staff necessary to properly administer the
617 corporation. Staff costs shall be funded from state and local
618 matching funds and such other private or public funds as become
619 available. The board of directors shall determine the number of
620 staff members necessary to administer the corporation.

621 14. In consultation with the partner agencies, provide an
622 annual ~~a~~ report on the Florida Kidcare program ~~annually~~ to the
623 Governor, the Chief Financial Officer, the Commissioner of
624 Education, the President of the Senate, the Speaker of the House
625 of Representatives, and the Minority Leaders of the Senate and
626 the House of Representatives.

627 15. Provide information on a quarterly basis to the
628 Legislature and the Governor which compares the costs and
629 utilization of the full-pay enrolled population and the Title
630 XXI-subsidized enrolled population in the Florida Kidcare
631 program. ~~The information,~~ At a minimum, the information must
632 include:

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

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

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By February 1, 2010, the Florida Healthy Kids Corporation shall provide a study to the Legislature and the Governor on premium impacts to the subsidized portion of the program from the inclusion of the full-pay program, which must ~~shall~~ include recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.

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

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

Section 10. Subsection (1) of section 409.813, Florida Statutes, is amended to read:

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

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

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668 (a) Medicaid.†
669 (b) Medikids as created in s. 409.8132.†
670 (c) The Florida Healthy Kids Corporation as created in s.
671 409.8115. ~~624.91;~~
672 (d) Employer-sponsored group health insurance plans
673 approved under this part. ~~ss. 409.810-409.821;~~ and
674 (e) The Children's Medical Services network ~~established in~~
675 ~~chapter 391.~~
676 Section 11. Subsection (4) of section 409.8132, Florida
677 Statutes, is amended to read:
678 409.8132 Medikids program component.—
679 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
680 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
681 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127,
682 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, ~~and~~ 409.9205,
683 409.987, 409.988, and 409.989 apply to the administration of the
684 Medikids program component of the Florida Kidcare program,
685 except that s. 409.987 ~~409.9122~~ applies to Medikids as modified
686 by ~~the provisions of~~ subsection (7).
687 Section 12. Subsection (1) of section 409.815, Florida
688 Statutes, is amended to read:
689 409.815 Health benefits coverage; limitations.—
690 (1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare
691 program, benefits available under Medicaid and Medikids include
692 those goods and services provided under the medical assistance
693 program authorized by Title XIX of the Social Security Act, and
694 regulations thereunder, as administered in this state by the
695 agency. This includes those mandatory Medicaid services
696 authorized under s. 409.905 and optional Medicaid services

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697 authorized under s. 409.906, rendered on behalf of eligible
698 individuals by qualified providers, in accordance with federal
699 requirements ~~for Title XIX~~, subject to any limitations or
700 directions provided ~~for~~ in the General Appropriations Act, ~~or~~
701 chapter 216, s. 409.9022, and according to methodologies and
702 limitations set forth in agency rules and policy manuals and
703 handbooks incorporated by reference ~~thereto~~.

704 Section 13. Subsection (5) of section 409.818, Florida
705 Statutes, is amended to read:

706 409.818 Administration.—In order to implement ss. 409.810-
707 409.821, the following agencies shall have the following duties:

708 (5) The Florida Healthy Kids Corporation shall retain its
709 functions as authorized in s. 409.8115 ~~624.91~~, including
710 eligibility determination for participation in the Healthy Kids
711 program.

712 Section 14. Paragraph (e) of subsection (2) of section
713 154.503, Florida Statutes, is amended to read:

714 154.503 Primary Care for Children and Families Challenge
715 Grant Program; creation; administration.—

716 (2) The department shall:

717 (e) Coordinate with the primary care program developed
718 pursuant to s. 154.011, the Florida Healthy Kids Corporation
719 program created in s. 409.8115 ~~624.91~~, the school health
720 services program created in ss. 381.0056 and 381.0057, the
721 Healthy Communities, Healthy People Program created in s.
722 381.734, and the volunteer health care provider program
723 established ~~developed~~ pursuant to s. 766.1115.

724 Section 15. Paragraph (c) of subsection (4) of section
725 408.915, Florida Statutes, is amended to read:

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726 408.915 Eligibility pilot project.—The Agency for Health
727 Care Administration, in consultation with the steering committee
728 established in s. 408.916, shall develop and implement a pilot
729 project to integrate the determination of eligibility for health
730 care services with information and referral services.

731 (4) The pilot project shall include eligibility
732 determinations for the following programs:

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

735 Section 16. Subsection (7) is added to section 1006.06,
736 Florida Statutes, to read:

737 1006.06 School food service programs.—

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

740 (a) At a minimum:

741 1. Provide application information about the Kidcare
742 program or an application for Kidcare to students at the
743 beginning of each school year.

744 2. Modify the school district's application form for the
745 lunch program under subsection (4) and the breakfast program
746 under subsection (5) to incorporate a provision that permits the
747 school district to share data from the application form with the
748 state agencies and the Florida Healthy Kids Corporation and its
749 agents that administer the Kidcare program unless the child's
750 parent or guardian opts out of the provision.

751 (b) At the option of the school district, share income and
752 other demographic data through an electronic interchange with
753 the Florida Healthy Kids Corporation and other state agencies in
754 order to determine eligibility for the Kidcare program on a

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755 regular and periodic basis.

756 (c) Establish interagency agreements ensuring that data
757 exchanged under this subsection is used only to enroll eligible
758 children in the Florida Kidcare program and is protected from
759 unauthorized disclosure pursuant to 42 U.S.C. s. 1758(b)(6).

760 Section 17. The Division of Statutory Revision is requested
761 to designate ss. 409.901 through 409.9205, Florida Statutes, as
762 part III of chapter 409, Florida Statutes, entitled "MEDICAID."

763 Section 18. Section 409.901, Florida Statutes, is amended
764 to read:

765 409.901 Definitions; ~~ss. 409.901-409.920.~~ As used in this
766 part and part IV ss. 409.901-409.920, except as otherwise
767 specifically provided, the term:

768 (1) "Affiliate" or "affiliated person" means any person who
769 directly or indirectly manages, controls, or oversees the
770 operation of a corporation or other business entity that is a
771 Medicaid provider, regardless of whether such person is a
772 partner, shareholder, owner, officer, director, agent, or
773 employee of the entity.

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

777 (3) "Applicant" means an individual whose written
778 application for medical assistance provided by Medicaid ~~under~~
779 ~~ss. 409.903-409.906~~ has been submitted to the Department of
780 Children and Family Services, or to the Social Security
781 Administration if the application is for Supplemental Security
782 Income, but has not received final action. The ~~This~~ term
783 includes an individual, who need not be alive at the time of

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784 application, and whose application is submitted through a
785 representative or a person acting for the individual.

786 (4) "Benefit" means any benefit, assistance, aid,
787 obligation, promise, debt, liability, or the like, related to
788 any covered injury, illness, or necessary medical care, goods,
789 or services.

790 (5) "Capitation" means a prospective per-member, per-month
791 payment designed to represent, in the aggregate, an actuarially
792 sound estimate of expenditures required for the management and
793 provision of a specified set of medical services or long-term
794 care services needed by members enrolled in a prepaid health
795 plan.

796 ~~(6)~~~~(5)~~ "Change of ownership" has the same meaning as in s.
797 408.803 and includes means:

798 ~~(a) An event in which the provider ownership changes to a~~
799 ~~different individual entity as evidenced by a change in federal~~
800 ~~employer identification number or taxpayer identification~~
801 ~~number;~~

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

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

810

811 ~~A change solely in the management company or board of directors~~
812 ~~is not a change of ownership.~~

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813 (7)~~(6)~~ "Claim" means any communication, whether written or
814 electronic (electronic impulse or magnetic), which is used by
815 any person to apply for payment from the Medicaid program, ~~or~~
816 its fiscal agent, or a qualified plan under part IV of this
817 chapter for each item or service purported ~~by any person~~ to have
818 been provided ~~by a person~~ to a ~~any~~ Medicaid recipient.

819 (8)~~(7)~~ "Collateral" means:

820 (a) Any and all causes of action, suits, claims,
821 counterclaims, and demands that accrue to a ~~the~~ recipient or to
822 a ~~the~~ recipient's legal representative, related to any covered
823 injury, illness, or necessary medical care, goods, or services
824 that resulted in necessitated that Medicaid providing ~~provide~~
825 medical assistance.

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

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

830 (9)~~(8)~~ "Convicted" or "conviction" means a finding of
831 guilt, with or without an adjudication of guilt, in any federal
832 or state trial court ~~of record relating to charges brought by~~
833 ~~indictment or information~~, as a result of a jury verdict,
834 nonjury trial, or entry of a plea of guilty or nolo contendere,
835 regardless of whether an appeal from judgment is pending.

836 (10)~~(9)~~ "Covered injury or illness" means any sickness,
837 injury, disease, disability, deformity, abnormality disease,
838 necessary medical care, pregnancy, or death for which a third
839 party is, may be, could be, should be, or has been liable, and
840 for which Medicaid is, or may be, obligated to provide, or has
841 provided, medical assistance.

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842 (11)~~(10)~~ "Emergency medical condition" has the same meaning
843 as in s. 395.002. ~~means:~~

844 ~~(a) A medical condition manifesting itself by acute~~
845 ~~symptoms of sufficient severity, which may include severe pain~~
846 ~~or other acute symptoms, such that the absence of immediate~~
847 ~~medical attention could reasonably be expected to result in any~~
848 ~~of the following:~~

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

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

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

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

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

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

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

860 (12)~~(11)~~ "Emergency services and care" has the same meaning
861 as in s. 395.002 ~~means medical screening, examination, and~~
862 ~~evaluation by a physician, or, to the extent permitted by~~
863 ~~applicable laws, by other appropriate personnel under the~~
864 ~~supervision of a physician, to determine whether an emergency~~
865 ~~medical condition exists and, if it does, the care, treatment,~~
866 ~~or surgery for a covered service by a physician which is~~
867 ~~necessary to relieve or eliminate the emergency medical~~
868 ~~condition, within the service capability of a hospital.~~

869 (13)~~(12)~~ "Legal representative" means a guardian,
870 conservator, survivor, or personal representative of a recipient

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871 or applicant, or of the property or estate of a recipient or
872 applicant.

873 (14)~~(13)~~ "Managed care plan" means a health insurer
874 authorized under chapter 624, an exclusive provider organization
875 authorized under chapter 627, a health maintenance organization
876 authorized under chapter 641, a provider service network
877 authorized under s. 409.912(4)(d), or an accountable care
878 organization authorized under federal law ~~health maintenance~~
879 ~~organization authorized pursuant to chapter 641 or a prepaid~~
880 ~~health plan authorized pursuant to s. 409.912.~~

881 (15)~~(14)~~ "Medicaid" or Medicaid program means the medical
882 assistance program authorized by Title XIX of the Social
883 Security Act, 42 U.S.C. s. 1396 et seq., and regulations
884 thereunder, as administered in this state by the agency.

885 ~~(15) "Medicaid agency" or "agency" means the single state~~
886 ~~agency that administers or supervises the administration of the~~
887 ~~state Medicaid plan under federal law.~~

888 ~~(16) "Medicaid program" means the program authorized under~~
889 ~~Title XIX of the federal Social Security Act which provides for~~
890 ~~payments for medical items or services, or both, on behalf of~~
891 ~~any person who is determined by the Department of Children and~~
892 ~~Family Services, or, for Supplemental Security Income, by the~~
893 ~~Social Security Administration, to be eligible on the date of~~
894 ~~service for Medicaid assistance.~~

895 (16)~~(17)~~ "Medicaid provider" or "provider" means a person
896 or entity that has a Medicaid provider agreement in effect with
897 the agency and is in good standing with the agency. The term
898 also includes a person or entity that provides medical services
899 to a Medicaid recipient under the Medicaid managed care program

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900 in part IV of this chapter.

901 (17)~~(18)~~ "Medicaid provider agreement" or "provider
902 agreement" means a contract between the agency and a provider
903 for the provision of services or goods, or both, to Medicaid
904 recipients pursuant to Medicaid.

905 (18)~~(19)~~ "Medicaid recipient" or "recipient" means an
906 individual whom the Department of Children and Family Services,
907 or, for Supplemental Security Income, ~~by~~ the Social Security
908 Administration, determines is eligible, pursuant to federal and
909 state law, to receive medical assistance and related services
910 for which the agency may make payments under the Medicaid
911 program. For the purposes of determining third-party liability,
912 the term includes an individual formerly determined to be
913 eligible for Medicaid, an individual who has received medical
914 assistance under ~~the Medicaid program~~, or an individual on whose
915 behalf Medicaid has become obligated.

916 (19)~~(20)~~ "Medicaid-related records" means records that
917 relate to the provider's business or profession and to a
918 Medicaid recipient. The term includes ~~Medicaid-related records~~
919 ~~include~~ records related to non-Medicaid customers, clients, or
920 patients but only to the extent that the documentation is shown
921 by the agency to be necessary for determining ~~to determine~~ a
922 provider's entitlement to payments under the Medicaid program.

923 (20)~~(21)~~ "Medical assistance" means any provision of,
924 payment for, or liability for medical services or care by
925 Medicaid to, or on behalf of, a Medicaid ~~any~~ recipient.

926 (21)~~(22)~~ "Medical services" or "medical care" means medical
927 or medically related institutional or noninstitutional care,
928 goods, or services covered by the Medicaid program. The term

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929 includes any services authorized and funded in the General
930 Appropriations Act.

931 ~~(22)~~(23) "MediPass" means a primary care case management
932 program operated by the agency.

933 ~~(23)~~(24) "Minority physician network" means a network of
934 primary care physicians with experience in managing Medicaid or
935 Medicare recipients which ~~that~~ is predominantly owned by
936 minorities, as defined in s. 288.703, and which may have a
937 collaborative partnership with a public college or university
938 and a tax-exempt charitable corporation.

939 ~~(24)~~(25) "Payment," as it relates to third-party benefits,
940 means performance of a duty, promise, or obligation, or
941 discharge of a debt or liability, by the delivery, provision, or
942 transfer of third-party benefits for medical services. To "pay"
943 means to do any of the acts set forth in this subsection.

944 ~~(25)~~(26) "Proceeds" means whatever is received upon the
945 sale, exchange, collection, or other disposition of the
946 collateral or proceeds thereon and includes insurance payable by
947 reason of loss or damage to the collateral or proceeds. Money,
948 checks, deposit accounts, and the like are "cash proceeds." All
949 other proceeds are "noncash proceeds."

950 ~~(26)~~(27) "Third party" means an individual, entity, or
951 program, excluding Medicaid, that is, may be, could be, should
952 be, or has been liable for all or part of the cost of medical
953 services related to any medical assistance covered by Medicaid.
954 A third party includes a third-party administrator or a pharmacy
955 benefits manager.

956 ~~(27)~~(28) "Third-party benefit" means any benefit that is or
957 may be available at any time through contract, court award,

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958 judgment, settlement, agreement, or any arrangement between a
959 third party and any person or entity, including, without
960 limitation, a Medicaid recipient, a provider, another third
961 party, an insurer, or the agency, for any Medicaid-covered
962 injury, illness, goods, or services, including costs of medical
963 services related thereto, for personal injury or for death of
964 the recipient, but specifically excluding policies of life
965 insurance on the recipient, unless available under terms of the
966 policy to pay medical expenses prior to death. The term
967 includes, without limitation, collateral, as defined in this
968 section, health insurance, any benefit under a health
969 maintenance organization, a preferred provider arrangement, a
970 prepaid health clinic, liability insurance, uninsured motorist
971 insurance or personal injury protection coverage, medical
972 benefits under workers' compensation, and any obligation under
973 law or equity to provide medical support.

974 Section 19. Section 409.902, Florida Statutes, is amended
975 to read:

976 409.902 Designated single state agency; eligibility
977 determinations; rules ~~payment requirements; program title;~~
978 ~~release of medical records.-~~

979 (1) The agency ~~for Health Care Administration~~ is designated
980 as the single state agency authorized to administer the Medicaid
981 state plan and to make payments for medical assistance and
982 related services under Title XIX of the Social Security Act.
983 These payments shall be made, subject to any limitations or
984 directions provided for in the General Appropriations Act, only
985 for services included in the Medicaid program, ~~shall be made~~
986 only on behalf of eligible individuals, and ~~shall be made~~ only

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987 to qualified providers in accordance with federal requirements
988 under ~~for~~ Title XIX of the Social Security Act and ~~the~~
989 ~~provisions of state law.~~

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

993 (b) The agency shall adopt any rules necessary to carry out
994 its statutory duties under this subsection and any other
995 statutory provisions related to its responsibility for the
996 Medicaid program and state compliance with federal Medicaid
997 requirements, including the Medicaid managed care program. ~~This~~
998 ~~program of medical assistance is designated the "Medicaid~~
999 ~~program."~~

1000 (2) The Department of Children and Family Services is
1001 responsible for determining Medicaid eligibility determinations,
1002 including, but not limited to, policy, rules, and the agreement
1003 with the Social Security Administration for Medicaid eligibility
1004 determinations for Supplemental Security Income recipients, as
1005 well as the actual determination of eligibility. ~~As a condition~~
1006 ~~of Medicaid eligibility, subject to federal approval, the agency~~
1007 ~~for Health Care Administration and the Department of Children~~
1008 ~~and Family Services shall ensure that each recipient of Medicaid~~
1009 ~~consents to the release of her or his medical records to the~~
1010 ~~agency for Health Care Administration and the Medicaid Fraud~~
1011 ~~Control Unit of the Department of Legal Affairs.~~

1012 (a) Eligibility is restricted to United States citizens and
1013 to lawfully admitted noncitizens who meet the criteria provided
1014 in s. 414.095(3).

1015 1. Citizenship or immigration status must be verified. For

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1016 noncitizens, this includes verification of the validity of
1017 documents with the United States Citizenship and Immigration
1018 Services using the federal SAVE verification process.

1019 2. State funds may not be used to provide medical services
1020 to individuals who do not meet the requirements of this
1021 paragraph unless the services are necessary to treat an
1022 emergency medical condition or are for pregnant women. Such
1023 services are authorized only to the extent provided under
1024 federal law and in accordance with federal regulations as
1025 provided in 42 C.F.R. s. 440.255.

1026 (b) In determining eligibility for nursing facility
1027 services, including institutional hospice services and home and
1028 community-based waiver programs under the Medicaid program,
1029 individuals who enter into a personal services contract with a
1030 relative on or after October 1, 2011, are considered to have
1031 transferred assets without fair compensation in order to qualify
1032 for Medicaid unless the following criteria are met:

1033 1. The contracted services do not duplicate services
1034 available through other sources or providers, such as Medicaid,
1035 Medicare, private insurance, or another legally obligated third
1036 party;

1037 2. The contracted services directly benefit the individual
1038 and are not services normally provided out of love and
1039 consideration for the individual;

1040 3. The actual cost to deliver services is computed in a
1041 manner that clearly reflects the actual number of hours to be
1042 expended, and the contract clearly identifies each specific
1043 service and the average number of hours of each service to be
1044 delivered each month;

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1045 4. The hourly rate for each contracted service is equal to
1046 or less than the amount normally charged by a professional who
1047 traditionally provides the same or similar services;

1048 5. The contracted services are provided on a prospective
1049 basis only and not for services provided in the past; and

1050 6. The contract provides fair compensation to the
1051 individual in his or her lifetime as set forth in life
1052 expectancy tables adopted in rule 65A-1.716, Florida
1053 Administrative Code.

1054 (c) The department shall adopt any rules necessary to carry
1055 out its statutory duties under this subsection for receiving and
1056 processing Medicaid applications and determining Medicaid
1057 eligibility, and any other statutory provisions related to
1058 responsibility for the determination of Medicaid eligibility.

1059 Section 20. Section 409.9021, Florida Statutes, is amended
1060 to read:

1061 409.9021 Conditions for Medicaid ~~Forfeiture of eligibility~~
1062 ~~agreement.~~—As a condition of Medicaid eligibility, subject to
1063 federal regulation and approval;~~7~~

1064 (1) A Medicaid applicant must consent ~~shall agree~~ in
1065 writing to:

1066 (a) Have her or his medical records released to the agency
1067 and the Medicaid Fraud Control Unit of the Department of Legal
1068 Affairs.

1069 (b) Forfeit all entitlements to any goods or services
1070 provided through the Medicaid program for the next 10 years if
1071 he or she has been found to have committed Medicaid fraud,
1072 through judicial or administrative determination, ~~two times in a~~
1073 ~~period of 5 years.~~ This provision applies only to the Medicaid

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1074 recipient found to have committed or participated in Medicaid
1075 ~~the~~ fraud and does not apply to any family member of the
1076 recipient who was not involved in the fraud.

1077 (2) A Medicaid applicant must pay a \$10 monthly premium
1078 that covers all Medicaid-eligible recipients in the applicant's
1079 family. However, an individual who is eligible for the
1080 Supplemental Security Income related Medicaid and is receiving
1081 institutional care payments is exempt from this requirement. The
1082 agency shall seek a federal waiver to authorize the imposition
1083 and collection of this premium effective December 31, 2011. Upon
1084 approval, the agency shall establish by rule procedures for
1085 collecting premiums from recipients, advance notice of
1086 cancellation, and waiting periods for reinstatement of coverage
1087 upon voluntary cancellation for nonpayment of premiums.

1088 (3) A Medicaid applicant must participate, in good faith,
1089 in:

1090 (a) A medically approved smoking cessation program if the
1091 applicant smokes.

1092 (b) A medically directed weight loss program if the
1093 applicant is or becomes morbidly obese.

1094 (c) A medically approved alcohol or substance abuse
1095 recovery program if the applicant is or becomes diagnosed as a
1096 substance abuser.

1097
1098 The agency shall seek a federal waiver to authorize the
1099 implementation of this subsection in order to assist the
1100 recipient in mitigating lifestyle choices and avoiding behaviors
1101 associated with the use of high-cost medical services.

1102 (4) A person who is eligible for Medicaid services and who

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1103 has access to health care coverage through an employer-sponsored
1104 health plan may not receive Medicaid services reimbursed under
1105 s. 409.908, s. 409.912, or s. 409.986, but may use Medicaid
1106 financial assistance to pay the cost of premiums for the
1107 employer-sponsored health plan for the eligible person and his
1108 or her Medicaid-eligible family members.

1109 (5) A Medicaid recipient who has access to other insurance
1110 or coverage created pursuant to state or federal law may opt out
1111 of the Medicaid services provided under s. 409.908, s. 409.912,
1112 or s. 409.986 and use Medicaid financial assistance to pay the
1113 cost of premiums for the recipient and the recipient's Medicaid
1114 eligible family members.

1115 (6) Subsections (4) and (5) shall be administered by the
1116 agency in accordance with s. 409.964(1)(h). The maximum amount
1117 available for the Medicaid financial assistance shall be
1118 calculated based on the Medicaid capitated rate as if the
1119 Medicaid recipient and the recipient's eligible family members
1120 participated in a qualified plan for Medicaid managed care under
1121 part IV of this chapter.

1122 Section 21. Section 409.9022, Florida Statutes, is created
1123 to read:

1124 409.9022 Limitations on Medicaid expenditures.-

1125 (1) Except as specifically authorized in this section, a
1126 state agency may not obligate or expend funds for the Medicaid
1127 program in excess of the amount appropriated in the General
1128 Appropriations Act.

1129 (2) If, at any time during the fiscal year, a state agency
1130 determines that Medicaid expenditures may exceed the amount
1131 appropriated during the fiscal year, the state agency shall

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1132 notify the Social Services Estimating Conference, which shall
1133 meet to estimate Medicaid expenditures for the remainder of the
1134 fiscal year. If, pursuant to this paragraph or for any other
1135 purpose, the conference determines that Medicaid expenditures
1136 will exceed appropriations for the fiscal year, the state agency
1137 shall develop and submit a plan for revising Medicaid
1138 expenditures in order to remain within the annual appropriation.
1139 The plan must include cost-mitigating strategies to negate the
1140 projected deficit for the remainder of the fiscal year and shall
1141 be submitted in the form of a budget amendment to the
1142 Legislative Budget Commission. The conference shall also
1143 estimate the amount of savings which will result from such cost-
1144 mitigating strategies proposed by the state agency as well as
1145 any other strategies the conference may consider and recommend.

1146 (3) In preparing the budget amendment to revise Medicaid
1147 expenditures in order to remain within appropriations, a state
1148 agency shall include the following revisions to the Medicaid
1149 state plan, in the priority order listed below:

1150 (a) Reduction in administrative costs.

1151 (b) Elimination of optional benefits.

1152 (c) Elimination of optional eligibility groups.

1153 (d) Reduction to institutional and provider reimbursement
1154 rates.

1155 (e) Reduction in the amount, duration, and scope of
1156 mandatory benefits.

1157
1158 The state agency may not implement any of these cost-containment
1159 measures until the amendment is approved by the Legislative
1160 Budget Commission.

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1161 (4) In order to remedy a projected expenditure in excess of
1162 the amount appropriated in a specific appropriation within the
1163 Medicaid budget, a state agency may, consistent with chapter
1164 216:

1165 (a) Submit a budget amendment to transfer budget authority
1166 between appropriation categories;

1167 (b) Submit a budget amendment to increase federal trust
1168 authority or grants and donations trust authority if additional
1169 federal or local funds are available; or

1170 (c) Submit any other budget amendment consistent with
1171 chapter 216.

1172 (5) The agency shall amend the Medicaid state plan to
1173 incorporate the provisions of this section.

1174 (6) Chapter 216 does not permit the transfer of funds from
1175 any other program into the Medicaid program or the transfer of
1176 funds out of the Medicaid program into any other program.

1177 Section 22. Section 409.903, Florida Statutes, is amended
1178 to read:

1179 409.903 Mandatory payments for eligible persons.—The agency
1180 shall make payments for medical assistance and related services
1181 on behalf of the following categories of persons who the
1182 Department of Children and Family Services, or the Social
1183 Security Administration by contract with the department ~~of~~
1184 ~~Children and Family Services~~, determines to be eligible for
1185 Medicaid, subject to the income, assets, and categorical
1186 eligibility tests set forth in federal and state law. Payment on
1187 behalf of these recipients ~~Medicaid eligible persons~~ is subject
1188 to the availability of moneys and any limitations established by
1189 the General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.

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1190 (1) Low-income families with children if ~~are eligible for~~
1191 ~~Medicaid provided~~ they meet the following requirements:

1192 (a) The family includes a dependent child who is living
1193 with a caretaker relative.

1194 (b) The family's income does not exceed the gross income
1195 test limit.

1196 (c) The family's countable income and resources do not
1197 exceed the applicable Aid to Families with Dependent Children
1198 (AFDC) income and resource standards under the AFDC state plan
1199 in effect on ~~in~~ July 1996, except as amended in the Medicaid
1200 state plan to conform as closely as possible to the requirements
1201 of the welfare transition program, to the extent permitted by
1202 federal law.

1203 (2) A person who receives payments from, who is determined
1204 eligible for, or who was eligible for but lost cash benefits
1205 from the federal program known as the Supplemental Security
1206 Income program (SSI). This ~~category~~ includes a low-income person
1207 age 65 or over and a low-income person under age 65 considered
1208 to be permanently and totally disabled.

1209 (3) A child under age 21 living in a low-income, two-parent
1210 family, and a child under age 7 living with a nonrelative, ~~if~~
1211 the income and assets of the family or child, as applicable, do
1212 not exceed the resource limits under the Temporary Cash
1213 Assistance Program.

1214 (4) A child who is eligible under Title IV-E of the Social
1215 Security Act for subsidized board payments, foster care, or
1216 adoption subsidies, and a child for whom the state has assumed
1217 temporary or permanent responsibility and who does not qualify
1218 for Title IV-E assistance but is in foster care, shelter or

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1219 emergency shelter care, or subsidized adoption. This ~~category~~
1220 includes a young adult who is eligible to receive services under
1221 s. 409.1451(5), until the young adult reaches 21 years of age,
1222 without regard to any income, resource, or categorical
1223 eligibility test that is otherwise required. This ~~category~~ also
1224 includes a person who as a child was eligible under Title IV-E
1225 of the Social Security Act for foster care or the state-provided
1226 foster care and who is a participant in the Road-to-Independence
1227 Program.

1228 (5) A pregnant woman for the duration of her pregnancy and
1229 for the postpartum period as defined in federal law and rule, or
1230 a child under age 1, if either is living in a family that has an
1231 income which is at or below ~~150 percent of the most current~~
1232 ~~federal poverty level, or, effective January 1, 1992, that has~~
1233 ~~an income which is at or below~~ 185 percent of the most current
1234 federal poverty level. Such a person is not subject to an assets
1235 test. ~~Further,~~ A pregnant woman who applies for eligibility for
1236 the Medicaid program through a qualified Medicaid provider must
1237 be offered the opportunity, subject to federal rules, to be made
1238 presumptively eligible for the Medicaid program.

1239 (6) A child ~~born after September 30, 1983,~~ living in a
1240 family that has an income which is at or below 100 percent of
1241 the current federal poverty level, who has attained the age of
1242 6, but has not attained the age of 19. In determining the
1243 eligibility of such a child, an assets test is not required. A
1244 child who is eligible ~~for Medicaid~~ under this subsection must be
1245 offered the opportunity, subject to federal rules, to be made
1246 presumptively eligible. A child who has been deemed
1247 presumptively eligible may ~~for Medicaid shall~~ not be enrolled in

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1248 a managed care plan until the child's full eligibility
1249 ~~determination~~ for Medicaid has been determined ~~completed~~.

1250 (7) A child living in a family that has an income that
1251 ~~which~~ is at or below 133 percent of the current federal poverty
1252 level, who has attained the age of 1, but has not attained the
1253 age of 6. In determining ~~the~~ eligibility ~~of such a child~~, an
1254 assets test is not required. A child who is eligible ~~for~~
1255 ~~Medicaid~~ under this subsection must be offered the opportunity,
1256 subject to federal rules, to be made presumptively eligible. A
1257 child who has been deemed presumptively eligible may ~~for~~
1258 ~~Medicaid shall~~ not be enrolled in a managed care plan until the
1259 child's full eligibility ~~determination~~ for Medicaid has been
1260 determined ~~completed~~.

1261 (8) A person who is age 65 or over or is determined by the
1262 agency to be disabled, whose income is at or below 100 percent
1263 of the most current federal poverty level and whose assets do
1264 not exceed limitations established by the agency. However, the
1265 agency may only pay for premiums, coinsurance, and deductibles,
1266 as required by federal law, unless additional coverage is
1267 provided for any or all members of this group under ~~by~~ s.
1268 409.904(1).

1269 Section 23. Section 409.904, Florida Statutes, is amended
1270 to read:

1271 409.904 Optional payments for eligible persons.—The agency
1272 may make payments for medical assistance and related services on
1273 behalf of the following categories of persons who are determined
1274 to be eligible for Medicaid, subject to the income, assets, and
1275 categorical eligibility tests set forth in federal and state
1276 law. Payment on behalf of these ~~Medicaid-eligible~~ persons is

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1277 subject to the availability of moneys and any limitations
1278 established by the General Appropriations Act, ~~or~~ chapter 216,
1279 or s. 409.9022.

1280 (1) ~~Effective January 1, 2006,~~ and Subject to federal
1281 waiver approval, a person who is age 65 or older or is
1282 determined to be disabled, whose income is at or below 88
1283 percent of the federal poverty level, whose assets do not exceed
1284 established limitations, and who is not eligible for Medicare
1285 or, if eligible for Medicare, is also eligible for and receiving
1286 Medicaid-covered institutional care services, hospice services,
1287 or home and community-based services. The agency shall seek
1288 federal authorization through a waiver to provide this coverage.
1289 This subsection expires June 30, 2011.

1290 (2) The following persons who are eligible for the Medicaid
1291 nonpoverty medical subsidy, which includes the same services as
1292 those provided to other Medicaid recipients, with the exception
1293 of services in skilled nursing facilities and intermediate care
1294 facilities for the developmentally disabled:

1295 (a) A family, a pregnant woman, a child under age 21, a
1296 person age 65 or over, or a blind or disabled person, who would
1297 be eligible under any group listed in s. 409.903(1), (2), or
1298 (3), except that the income or assets of such family or person
1299 exceed established limitations. For a family or person in one of
1300 these coverage groups, medical expenses are deductible from
1301 income in accordance with federal requirements in order to make
1302 a determination of eligibility. ~~A family or person eligible~~
1303 ~~under the coverage known as the "medically needy," is eligible~~
1304 ~~to receive the same services as other Medicaid recipients, with~~
1305 ~~the exception of services in skilled nursing facilities and~~

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1306 ~~intermediate care facilities for the developmentally disabled.~~
1307 This paragraph expires June 30, 2011.

1308 (b) Effective June 30 ~~July 1~~, 2011, a pregnant woman or a
1309 child younger than 21 years of age who would be eligible under
1310 any group listed in s. 409.903, except that the income or assets
1311 of such group exceed established limitations. For a person in
1312 one of these coverage groups, medical expenses are deductible
1313 from income in accordance with federal requirements in order to
1314 make a determination of eligibility. ~~A person eligible under the~~
1315 ~~coverage known as the "medically needy" is eligible to receive~~
1316 ~~the same services as other Medicaid recipients, with the~~
1317 ~~exception of services in skilled nursing facilities and~~
1318 ~~intermediate care facilities for the developmentally disabled.~~

1319 (c) A family, a person age 65 or older, or a blind or
1320 disabled person, who would be eligible under any group listed in
1321 s. 409.903(1), (2), or (3), except that the income or assets of
1322 such family or person exceed established limitations. For a
1323 family or person in one of these coverage groups, medical
1324 expenses are deductible from income in accordance with federal
1325 requirements in order to make a determination of eligibility. A
1326 family, a person age 65 or older, or a blind or disabled person,
1327 covered under the Medicaid nonpoverty medical subsidy, is
1328 eligible to receive physician services only.

1329 (3) A person who is in need of the services of a licensed
1330 nursing facility, a licensed intermediate care facility for the
1331 developmentally disabled, or a state mental hospital, whose
1332 income does not exceed 300 percent of the SSI income standard,
1333 and who meets the assets standards established under federal and
1334 state law. In determining the person's responsibility for the

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1335 cost of care, the following amounts must be deducted from the
1336 person's income:

1337 (a) The monthly personal allowance for residents as set
1338 based on appropriations.

1339 (b) The reasonable costs of medically necessary services
1340 and supplies that are not reimbursable by the Medicaid program.

1341 (c) The cost of premiums, copayments, coinsurance, and
1342 deductibles for supplemental health insurance.

1343 (4) A low-income person who meets all other requirements
1344 for Medicaid eligibility except citizenship and who is in need
1345 of emergency medical services. The eligibility of such a
1346 recipient is limited to the period of the emergency, in
1347 accordance with federal regulations.

1348 (5) Subject to specific federal authorization, a woman
1349 living in a family that has an income that is at or below 185
1350 percent of the most current federal poverty level. Coverage is
1351 limited to ~~is eligible for~~ family planning services as specified
1352 in s. 409.905(3) for a period of up to 24 months following a
1353 loss of Medicaid benefits.

1354 (6) A child who has not attained the age of 19 who has been
1355 determined eligible for the Medicaid program is deemed to be
1356 eligible for a total of 6 months, regardless of changes in
1357 circumstances other than attainment of the maximum age.

1358 ~~Effective January 1, 1999,~~ A child who has not attained the age
1359 of 5 and who has been determined eligible for the Medicaid
1360 program is deemed to be eligible for a total of 12 months
1361 regardless of changes in circumstances other than attainment of
1362 the maximum age.

1363 (7) A child under 1 year of age who lives in a family that

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1364 has an income above 185 percent of the most recently published
1365 federal poverty level, but which is at or below 200 percent of
1366 such poverty level. In determining the eligibility ~~of such~~
1367 ~~child~~, an assets test is not required. A child who is eligible
1368 ~~for Medicaid~~ under this subsection must be offered the
1369 opportunity, subject to federal rules, to be made presumptively
1370 eligible.

1371 (8) An eligible person ~~A Medicaid-eligible individual~~ for
1372 the individual's health insurance premiums, if the agency
1373 determines that such payments are cost-effective.

1374 (9) Eligible women with incomes at or below 200 percent of
1375 the federal poverty level and under age 65, for cancer treatment
1376 pursuant to the federal Breast and Cervical Cancer Prevention
1377 and Treatment Act of 2000, screened through the Mary Brogan
1378 Breast and Cervical Cancer Early Detection Program established
1379 under s. 381.93.

1380 Section 24. Section 409.905, Florida Statutes, is amended
1381 to read:

1382 409.905 Mandatory Medicaid services.—The agency shall ~~may~~
1383 make payments for the following services, which are required ~~of~~
1384 ~~the state~~ by Title XIX of the Social Security Act, furnished by
1385 Medicaid providers to recipients who are ~~determined to be~~
1386 eligible on the dates on which the services were provided. Any
1387 service under this section shall be provided only when medically
1388 necessary and in accordance with state and federal law.
1389 Mandatory services rendered by providers in mobile units to
1390 Medicaid recipients may be restricted by the agency. This
1391 section does not ~~Nothing in this section shall be construed to~~
1392 prevent or limit the agency from adjusting fees, reimbursement

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1393 rates, lengths of stay, number of visits, number of services, or
1394 any other adjustments necessary to comply with the availability
1395 of moneys and any limitations or directions provided ~~for~~ in the
1396 General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.

1397 (1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The
1398 agency shall pay for services provided to a recipient by a
1399 licensed advanced registered nurse practitioner who has a valid
1400 collaboration agreement with a licensed physician on file with
1401 the Department of Health or who provides anesthesia services in
1402 accordance with established protocol required by state law and
1403 approved by the medical staff of the facility in which the
1404 ~~anesthetic~~ service is performed. Reimbursement for such services
1405 must be provided in an amount that equals at least ~~not less than~~
1406 80 percent of the reimbursement to a physician who provides the
1407 same services, unless otherwise provided ~~for~~ in the General
1408 Appropriations Act.

1409 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
1410 SERVICES.—The agency shall pay for early and periodic screening
1411 and diagnosis of a recipient under age 21 to ascertain physical
1412 and mental problems and conditions and ~~provide treatment to~~
1413 ~~correct or ameliorate these problems and conditions. These~~
1414 ~~services include~~ all services determined by the agency to be
1415 medically necessary for the treatment, correction, or
1416 amelioration of these problems and conditions, including
1417 personal care, private duty nursing, durable medical equipment,
1418 physical therapy, occupational therapy, speech therapy,
1419 respiratory therapy, and immunizations.

1420 (3) FAMILY PLANNING SERVICES.—The agency shall pay for
1421 services necessary to enable a recipient voluntarily to plan

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1422 family size or to space children. These services include
1423 information; education; counseling regarding the availability,
1424 benefits, and risks of each method of pregnancy prevention;
1425 drugs and supplies; and necessary medical care and followup.
1426 Each recipient participating in ~~the family planning portion of~~
1427 ~~the Medicaid program~~ must be provided the choice of freedom to
1428 ~~choose~~ any alternative method of family planning, as required by
1429 federal law.

1430 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
1431 nursing and home health aide services, supplies, appliances, and
1432 durable medical equipment, necessary to assist a recipient
1433 living at home. An entity that provides such services must
1434 ~~pursuant to this subsection shall~~ be licensed under part III of
1435 chapter 400. These services, equipment, and supplies, or
1436 reimbursement therefor, may be limited as provided in the
1437 General Appropriations Act and do not include services,
1438 equipment, or supplies provided to a person residing in a
1439 hospital or nursing facility.

1440 (a) ~~In providing home health care services,~~ The agency
1441 shall may require prior authorization of home health services
1442 ~~care~~ based on diagnosis, utilization rates, and ~~or~~ billing
1443 rates. ~~The agency shall require prior authorization for visits~~
1444 ~~for home health services that are not associated with a skilled~~
1445 ~~nursing visit when the home health agency billing rates exceed~~
1446 ~~the state average by 50 percent or more.~~ The home health agency
1447 must submit the recipient's plan of care and documentation that
1448 supports the recipient's diagnosis to the agency when requesting
1449 prior authorization.

1450 (b) The agency shall implement a comprehensive utilization

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1451 management program ~~that requires prior authorization~~ of all
 1452 private duty nursing services, an individualized treatment plan
 1453 that includes information about medication and treatment orders,
 1454 treatment goals, methods of care to be used, and plans for care
 1455 coordination by nurses and other health professionals. The
 1456 utilization management program must ~~shall~~ also include a process
 1457 for periodically reviewing the ongoing use of private duty
 1458 nursing services. The assessment of need shall be based on a
 1459 child's condition;; family support and care supplements;; a
 1460 family's ability to provide care;; ~~and~~ a family's and child's
 1461 schedule regarding work, school, sleep, and care for other
 1462 family dependents; and a determination of the medical necessity
 1463 for private duty nursing instead of other more cost-effective
 1464 in-home services. When implemented, the private duty nursing
 1465 utilization management program shall replace the current
 1466 authorization program used by the agency ~~for Health Care~~
 1467 ~~Administration~~ and the Children's Medical Services program of
 1468 the Department of Health. The agency may competitively bid ~~on~~ a
 1469 contract to select a qualified organization to provide
 1470 utilization management of private duty nursing services. The
 1471 agency may ~~is authorized to~~ seek federal waivers to implement
 1472 this initiative.

1473 (c) The agency may not pay for home health services unless
 1474 the services are medically necessary and:

- 1475 1. The services are ordered by a physician.
- 1476 2. The written prescription for the services is signed and
 1477 dated by the recipient's physician before the development of a
 1478 plan of care and before any request requiring prior
 1479 authorization.

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1480 3. The physician ordering the services is not employed,
1481 under contract with, or otherwise affiliated with the home
1482 health agency rendering the services. However, this subparagraph
1483 does not apply to a home health agency affiliated with a
1484 retirement community, of which the parent corporation or a
1485 related legal entity owns a rural health clinic certified under
1486 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
1487 under part II of chapter 400, or an apartment or single-family
1488 home for independent living. For purposes of this subparagraph,
1489 the agency may, on a case-by-case basis, provide an exception
1490 for medically fragile children who are younger than 21 years of
1491 age.

1492 4. The physician ordering the services has examined the
1493 recipient within the 30 days preceding the initial request for
1494 the services and biannually thereafter.

1495 5. The written prescription for the services includes the
1496 recipient's acute or chronic medical condition or diagnosis, the
1497 home health service required, and, for skilled nursing services,
1498 the frequency and duration of the services.

1499 6. The national provider identifier, Medicaid
1500 identification number, or medical practitioner license number of
1501 the physician ordering the services is listed on the written
1502 prescription for the services, the claim for home health
1503 reimbursement, and the prior authorization request.

1504 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1505 all covered services provided for the medical care and treatment
1506 of a recipient who is admitted as an inpatient by a licensed
1507 physician or dentist to a hospital licensed under part I of
1508 chapter 395. However, the agency shall limit the payment for

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1509 inpatient hospital services for a Medicaid recipient 21 years of
1510 age or older to 45 days or the number of days necessary to
1511 comply with the General Appropriations Act.

1512 (a) The agency may ~~is authorized to~~ implement reimbursement
1513 and utilization management reforms in order to comply with any
1514 limitations or directions in the General Appropriations Act,
1515 which may include, but are not limited to: prior authorization
1516 for inpatient psychiatric days; prior authorization for
1517 nonemergency hospital inpatient admissions for individuals 21
1518 years of age and older; authorization of emergency and urgent-
1519 care admissions within 24 hours after admission; enhanced
1520 utilization and concurrent review programs for highly utilized
1521 services; reduction or elimination of covered days of service;
1522 adjusting reimbursement ceilings for variable costs; adjusting
1523 reimbursement ceilings for fixed and property costs; and
1524 implementing target rates of increase. The agency may limit
1525 prior authorization for hospital inpatient services to selected
1526 diagnosis-related groups, based on an analysis of the cost and
1527 potential for unnecessary hospitalizations represented by
1528 certain diagnoses. Admissions for normal delivery and newborns
1529 are exempt from requirements for prior authorization. In
1530 implementing the provisions of this section related to prior
1531 authorization, the agency must ~~shall~~ ensure that the process for
1532 authorization is accessible 24 hours per day, 7 days per week
1533 and that authorization is automatically granted if ~~when~~ not
1534 denied within 4 hours after the request. Authorization
1535 procedures must include steps for reviewing ~~review of~~ denials.
1536 Upon implementing the prior authorization program for hospital
1537 inpatient services, the agency shall discontinue its hospital

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1538 retrospective review program.

1539 (b) A licensed hospital maintained primarily for the care
1540 and treatment of patients having mental disorders or mental
1541 diseases may ~~is not eligible to~~ participate in the hospital
1542 inpatient portion of the Medicaid program except as provided in
1543 federal law. However, the Department of Children and Family
1544 Services shall apply for a waiver, ~~within 9 months after June 5,~~
1545 ~~1991,~~ designed to provide hospitalization services for mental
1546 health reasons to children and adults in the most cost-effective
1547 and lowest cost setting possible. Such waiver shall include a
1548 request for the opportunity to pay for care in hospitals known
1549 under federal law as "institutions for mental disease" or
1550 "IMD's." The waiver proposal shall propose no additional
1551 aggregate cost to the state or Federal Government, and shall be
1552 conducted in Hillsborough County, Highlands County, Hardee
1553 County, Manatee County, and Polk County. The waiver proposal may
1554 incorporate competitive bidding for hospital services,
1555 comprehensive brokering, prepaid capitated arrangements, or
1556 other mechanisms deemed by the department to show promise in
1557 reducing the cost of acute care and increasing the effectiveness
1558 of preventive care. When developing the waiver proposal, the
1559 department shall take into account price, quality,
1560 accessibility, linkages of the hospital to community services
1561 and family support programs, plans of the hospital to ensure the
1562 earliest discharge possible, and the comprehensiveness of the
1563 mental health and other health care services offered by
1564 participating providers.

1565 (c) The agency shall adjust a hospital's current inpatient
1566 per diem rate to reflect the cost of serving the Medicaid

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1567 population at that institution if:

1568 1. The hospital experiences an increase in Medicaid
1569 caseload by more than 25 percent in any year, primarily
1570 resulting from the closure of a hospital in the same service
1571 area occurring after July 1, 1995;

1572 2. The hospital's Medicaid per diem rate is at least 25
1573 percent below the Medicaid per patient cost for that year; or

1574 3. The hospital is located in a county that has six or
1575 fewer general acute care hospitals, began offering obstetrical
1576 services on or after September 1999, and has submitted a request
1577 in writing to the agency for a rate adjustment after July 1,
1578 2000, but before September 30, 2000, in which case such
1579 hospital's Medicaid inpatient per diem rate shall be adjusted to
1580 cost, effective July 1, 2002. By October 1 of each year, the
1581 agency must provide estimated costs for any adjustment in a
1582 hospital inpatient per diem rate to the Executive Office of the
1583 Governor, the House of Representatives General Appropriations
1584 Committee, and the Senate Appropriations Committee. Before the
1585 agency implements a change in a hospital's inpatient per diem
1586 rate pursuant to this paragraph, the Legislature must have
1587 specifically appropriated sufficient funds in the General
1588 Appropriations Act to support the increase in cost as estimated
1589 by the agency.

1590 (d) The agency shall implement a hospitalist program in
1591 nonteaching hospitals, select counties, or statewide. The
1592 program shall require hospitalists to manage Medicaid
1593 recipients' hospital admissions and lengths of stay. Individuals
1594 who are dually eligible for Medicare and Medicaid are exempted
1595 from this requirement. Medicaid participating physicians and

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1596 other practitioners with hospital admitting privileges shall
1597 coordinate and review admissions of Medicaid recipients with the
1598 hospitalist. The agency may competitively bid a contract for
1599 selection of a single qualified organization to provide
1600 hospitalist services. The agency may procure hospitalist
1601 services by individual county or may combine counties in a
1602 single procurement. The qualified organization shall contract
1603 with or employ board-eligible physicians in Miami-Dade, Palm
1604 Beach, Hillsborough, Pasco, and Pinellas Counties. The agency
1605 may ~~is authorized to~~ seek federal waivers to implement this
1606 program.

1607 (e) The agency shall implement a comprehensive utilization
1608 management program for hospital neonatal intensive care stays in
1609 certain high-volume participating hospitals, select counties, or
1610 statewide, and shall replace existing hospital inpatient
1611 utilization management programs for neonatal intensive care
1612 admissions. The program shall be designed to manage the lengths
1613 of stay for children being treated in neonatal intensive care
1614 units and must seek the earliest medically appropriate discharge
1615 to the child's home or other less costly treatment setting. The
1616 agency may competitively bid a contract for selection of a
1617 qualified organization to provide neonatal intensive care
1618 utilization management services. The agency may ~~is authorized to~~
1619 seek any federal waivers to implement this initiative.

1620 (f) The agency may develop and implement a program to
1621 reduce the number of hospital readmissions among the non-
1622 Medicare population eligible in areas 9, 10, and 11.

1623 (6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for
1624 preventive, diagnostic, therapeutic, or palliative care and

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1625 other services provided to a recipient in the outpatient portion
1626 of a hospital licensed under part I of chapter 395, and provided
1627 under the direction of a licensed physician or licensed dentist,
1628 except that payment for such care and services is limited to
1629 \$1,500 per state fiscal year per recipient, unless an exception
1630 has been made by the agency, and with the exception of a
1631 Medicaid recipient under age 21, in which case the only
1632 limitation is medical necessity.

1633 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay
1634 for medically necessary diagnostic laboratory procedures ordered
1635 by a licensed physician or other licensed health care
1636 practitioner ~~of the healing arts~~ which are provided for a
1637 recipient in a laboratory that meets the requirements for
1638 Medicare participation and is licensed under chapter 483, if
1639 required.

1640 (8) NURSING FACILITY SERVICES.—The agency shall pay for 24-
1641 hour-a-day nursing and rehabilitative services for a recipient
1642 in a nursing facility licensed under part II of chapter 400 or
1643 in a rural hospital, as defined in s. 395.602, or in a Medicare
1644 certified skilled nursing facility operated by a general
1645 hospital, as defined in ~~by~~ s. 395.002(10), which ~~that~~ is
1646 licensed under part I of chapter 395, and in accordance with
1647 ~~provisions set forth in~~ s. 409.908(2)(a), which services are
1648 ordered by and provided under the direction of a licensed
1649 physician. However, if a nursing facility has been destroyed or
1650 otherwise made uninhabitable by natural disaster or other
1651 emergency and another nursing facility is not available, the
1652 agency must pay for similar services temporarily in a hospital
1653 licensed under part I of chapter 395 provided federal funding is

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1654 approved and available. The agency shall pay only for bed-hold
1655 days if the facility has an occupancy rate of 95 percent or
1656 greater. The agency is authorized to seek any federal waivers to
1657 implement this policy.

1658 (9) PHYSICIAN SERVICES.—The agency shall pay for covered
1659 services and procedures rendered to a Medicaid recipient by, or
1660 under the personal supervision of, a person licensed under state
1661 law to practice medicine or osteopathic medicine. These services
1662 may be furnished in the physician's office, the ~~Medicaid~~
1663 recipient's home, a hospital, a nursing facility, or elsewhere,
1664 but must ~~shall~~ be medically necessary for the treatment of a
1665 covered ~~an~~ injury or, ~~illness, or disease~~ within the scope of
1666 the practice of medicine or osteopathic medicine as defined by
1667 state law. The agency may ~~shall~~ not pay for services that are
1668 clinically unproven, experimental, or for purely cosmetic
1669 purposes.

1670 (10) PORTABLE X-RAY SERVICES.—The agency shall pay for
1671 professional and technical portable radiological services
1672 ordered by a licensed physician or other licensed health care
1673 practitioner ~~of the healing arts~~ which are provided by a
1674 licensed professional in a setting other than a hospital,
1675 clinic, or office of a physician or practitioner ~~of the healing~~
1676 ~~arts~~, on behalf of a recipient.

1677 (11) RURAL HEALTH CLINIC SERVICES.—The agency shall pay for
1678 outpatient primary ~~health~~ care services for a recipient provided
1679 by a clinic certified by and participating in the Medicare
1680 program which is located in a federally designated, rural,
1681 medically underserved area and has on its staff one or more
1682 licensed primary care nurse practitioners or physician

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1683 assistants, and a licensed staff supervising physician or a
1684 consulting supervising physician.

1685 (12) TRANSPORTATION SERVICES.—The agency shall ensure that
1686 appropriate transportation services are available for a Medicaid
1687 recipient in need of transport to a qualified Medicaid provider
1688 for medically necessary ~~and Medicaid-compensable~~ services, if
1689 the recipient's ~~provided a client's~~ ability to choose a specific
1690 transportation provider is ~~shall be~~ limited to those options
1691 resulting from policies established by the agency to meet the
1692 fiscal limitations of the General Appropriations Act. The agency
1693 may pay for necessary transportation and other related travel
1694 expenses ~~as necessary~~ only if these services are not otherwise
1695 available.

1696 Section 25. Section 409.906, Florida Statutes, is amended
1697 to read:

1698 409.906 Optional Medicaid services.—Subject to specific
1699 appropriations, the agency may make payments for services which
1700 are optional to the state under Title XIX of the Social Security
1701 Act and are furnished by Medicaid providers to recipients who
1702 are determined to be eligible on the dates on which the services
1703 were provided. Any optional service that is provided shall be
1704 provided only when medically necessary and in accordance with
1705 state and federal law. Optional services rendered by providers
1706 in mobile units to Medicaid recipients may be restricted or
1707 prohibited by the agency. ~~Nothing in~~ This section does not ~~shall~~
1708 ~~be construed to~~ prevent or limit the agency from adjusting fees,
1709 reimbursement rates, lengths of stay, number of visits, or
1710 number of services, or making any other adjustments necessary to
1711 comply with the availability of moneys and any limitations or

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1712 directions provided for in the General Appropriations Act, ~~or~~
1713 chapter 216, or s. 409.9022. ~~If necessary to safeguard the~~
1714 ~~state's systems of providing services to elderly and disabled~~
1715 ~~persons and subject to the notice and review provisions of s.~~
1716 ~~216.177, the Governor may direct the Agency for Health Care~~
1717 ~~Administration to amend the Medicaid state plan to delete the~~
1718 ~~optional Medicaid service known as "Intermediate Care Facilities~~
1719 ~~for the Developmentally Disabled."~~ Optional services may
1720 include:

1721 (1) ADULT DENTAL SERVICES. For a recipient who is 21 years
1722 of age or older:

1723 (a) The agency may pay for medically necessary, emergency
1724 dental procedures to alleviate pain or infection. Emergency
1725 dental care is ~~shall be~~ limited to emergency oral examinations,
1726 necessary radiographs, extractions, and incision and drainage of
1727 abscess, ~~for a recipient who is 21 years of age or older.~~

1728 (b) ~~Beginning July 1, 2006,~~ The agency may pay for full or
1729 partial dentures, the procedures required to seat full or
1730 partial dentures, and the repair and reline of full or partial
1731 dentures, provided by or under the direction of a licensed
1732 dentist, ~~for a recipient who is 21 years of age or older.~~

1733 (c) ~~However,~~ Medicaid will not provide reimbursement for
1734 dental services provided in a mobile dental unit, except for a
1735 mobile dental unit:

1736 1. Owned by, operated by, or having a contractual agreement
1737 with the Department of Health and complying with Medicaid's
1738 county health department clinic services program specifications
1739 as a county health department clinic services provider.

1740 2. Owned by, operated by, or having a contractual

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1741 arrangement with a federally qualified health center and
1742 complying with Medicaid's federally qualified health center
1743 specifications as a federally qualified health center provider.

1744 3. Rendering dental services to Medicaid recipients, 21
1745 years of age and older, at nursing facilities.

1746 4. Owned by, operated by, or having a contractual agreement
1747 with a state-approved dental educational institution.

1748 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay for
1749 an annual routine physical examination, conducted by or under
1750 the direction of a licensed physician, for a recipient age 21 or
1751 older, without regard to medical necessity, in order to detect
1752 and prevent disease, disability, or other health condition or
1753 its progression.

1754 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay
1755 for services provided to a recipient in an ambulatory surgical
1756 center licensed under part I of chapter 395, by or under the
1757 direction of a licensed physician or dentist.

1758 (4) BIRTH CENTER SERVICES.—The agency may pay for
1759 examinations and delivery, recovery, ~~and~~ newborn assessment, and
1760 related services, provided in a licensed birth center staffed
1761 with licensed physicians, certified nurse midwives, and midwives
1762 licensed in accordance with chapter 467, to a recipient expected
1763 to experience a low-risk pregnancy and delivery.

1764 (5) CASE MANAGEMENT SERVICES.—The agency may pay for
1765 primary care case management services rendered to a recipient
1766 pursuant to a federally approved waiver, ~~and~~ targeted case
1767 management services for specific groups of targeted recipients,
1768 for which funding has been provided and which are rendered
1769 pursuant to federal guidelines. The agency may ~~is authorized to~~

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1770 limit reimbursement for targeted case management services in
1771 order to comply with any limitations or directions provided for
1772 in the General Appropriations Act.

1773 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for
1774 diagnostic, preventive, or corrective procedures, including
1775 orthodontia in severe cases, provided to a recipient under age
1776 21, by or under the supervision of a licensed dentist. Services
1777 ~~provided under this program~~ include treatment of the teeth and
1778 associated structures of the oral cavity, as well as treatment
1779 of disease, injury, or impairment that may affect the oral or
1780 general health of the individual. However, Medicaid may ~~will~~ not
1781 provide reimbursement for dental services provided in a mobile
1782 dental unit, except for a mobile dental unit:

1783 (a) Owned by, operated by, or having a contractual
1784 agreement with the Department of Health and complying with
1785 Medicaid's county health department clinic services program
1786 specifications as a county health department clinic services
1787 provider.

1788 (b) Owned by, operated by, or having a contractual
1789 arrangement with a federally qualified health center and
1790 complying with Medicaid's federally qualified health center
1791 specifications as a federally qualified health center provider.

1792 (c) Rendering dental services to Medicaid recipients, 21
1793 years of age and older, at nursing facilities.

1794 (d) Owned by, operated by, or having a contractual
1795 agreement with a state-approved dental educational institution.

1796 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual
1797 manipulation of the spine and initial services, screening, and X
1798 rays provided to a recipient by a licensed chiropractic

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1799 physician.

1800 (8) COMMUNITY MENTAL HEALTH SERVICES.—

1801 ~~(a)~~ The agency may pay for rehabilitative services provided
1802 to a recipient by a mental health or substance abuse provider
1803 under contract with the agency or the Department of Children and
1804 Family Services to provide such services. ~~These Services that~~
1805 ~~which~~ are psychiatric in nature must ~~shall~~ be rendered or
1806 recommended by a psychiatrist, and ~~these services that which~~ are
1807 medical in nature must ~~shall~~ be rendered or recommended by a
1808 physician or psychiatrist.

1809 (a) The agency shall ~~must~~ develop a provider enrollment
1810 process for community mental health providers which bases
1811 provider enrollment on an assessment of service need. The
1812 provider enrollment process shall be designed to control costs,
1813 prevent fraud and abuse, consider provider expertise and
1814 capacity, and assess provider success in managing utilization of
1815 care and measuring treatment outcomes. Providers must ~~will~~ be
1816 selected through a competitive procurement or selective
1817 contracting process. In addition ~~to other community mental~~
1818 ~~health providers,~~ the agency shall consider enrolling ~~for~~
1819 ~~enrollment~~ mental health programs licensed under chapter 395 and
1820 group practices licensed under chapter 458, chapter 459, chapter
1821 490, or chapter 491. The agency may ~~is~~ also ~~authorized to~~
1822 continue the operation of its behavioral health utilization
1823 management program and ~~may~~ develop new services, ~~if these~~
1824 ~~actions are necessary,~~ to ensure savings from the implementation
1825 of the utilization management system. The agency shall
1826 coordinate the implementation of this enrollment process with
1827 the Department of Children and Family Services and the

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1828 Department of Juvenile Justice. The agency may use ~~is authorized~~
1829 ~~to utilize~~ diagnostic criteria in setting reimbursement rates,
1830 ~~to~~ preauthorize certain high-cost or highly utilized services,
1831 ~~to~~ limit or eliminate coverage for certain services, or ~~to~~ make
1832 any other adjustments necessary to comply with any limitations
1833 or directions provided for in the General Appropriations Act.

1834 (b) The agency may ~~is authorized to~~ implement reimbursement
1835 and use management reforms in order to comply with any
1836 limitations or directions in the General Appropriations Act,
1837 which may include, but are not limited to: prior authorization
1838 of treatment and service plans; prior authorization of services;
1839 enhanced use review programs for highly used services; and
1840 limits on services for recipients ~~those~~ determined to be abusing
1841 their benefit coverages.

1842 (9) DIALYSIS FACILITY SERVICES.—Subject to specific
1843 appropriations being provided for this purpose, the agency may
1844 pay a dialysis facility that is approved as a dialysis facility
1845 in accordance with Title XVIII of the Social Security Act, for
1846 dialysis services that are provided to a Medicaid recipient
1847 under the direction of a physician licensed to practice medicine
1848 or osteopathic medicine in this state, including dialysis
1849 services provided in the recipient's home by a hospital-based or
1850 freestanding dialysis facility.

1851 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize
1852 and pay for certain durable medical equipment and supplies
1853 provided to a Medicaid recipient as medically necessary.

1854 (11) HEALTHY START SERVICES.—The agency may pay for a
1855 continuum of risk-appropriate medical and psychosocial services
1856 for the Healthy Start program in accordance with a federal

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1857 waiver. The agency may not implement the federal waiver unless
1858 the waiver permits the state to limit enrollment or the amount,
1859 duration, and scope of services to ensure that expenditures will
1860 not exceed funds appropriated by the Legislature or available
1861 from local sources. If ~~the Health Care Financing Administration~~
1862 ~~does not approve~~ a federal waiver for Healthy Start services is
1863 not approved, the agency, in consultation with the Department of
1864 Health and the Florida Association of Healthy Start Coalitions,
1865 may ~~is authorized to~~ establish a Medicaid certified-match
1866 program for Healthy Start services. Participation in the Healthy
1867 Start certified-match program is ~~shall be~~ voluntary, and
1868 reimbursement is ~~shall be~~ limited to the federal Medicaid share
1869 provided to Medicaid-enrolled Healthy Start coalitions for
1870 services provided to Medicaid recipients. The agency may not
1871 ~~shall~~ take ~~no~~ action to implement a certified-match program
1872 without ensuring that the amendment and review requirements of
1873 ss. 216.177 and 216.181 have been met.

1874 (12) HEARING SERVICES.—The agency may pay for hearing and
1875 related services, including hearing evaluations, hearing aid
1876 devices, dispensing of the hearing aid, and related repairs, ~~if~~
1877 provided to a recipient by a licensed hearing aid specialist,
1878 otolaryngologist, otologist, audiologist, or physician.

1879 (13) HOME AND COMMUNITY-BASED SERVICES.—

1880 (a) The agency may pay for home-based or community-based
1881 services that are rendered to a recipient in accordance with a
1882 federally approved waiver program. The agency may limit or
1883 eliminate coverage for certain services, preauthorize high-cost
1884 or highly utilized services, or make any other adjustments
1885 necessary to comply with any limitations or directions provided

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1886 ~~for~~ in the General Appropriations Act.

1887 (b) The agency may consolidate types of services offered in
1888 the Aged and Disabled Waiver, the Channeling Waiver, the Project
1889 AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury
1890 Waiver programs in order to group similar services under a
1891 single service, or continue a service upon evidence of the need
1892 for including a particular service type in a particular waiver.
1893 The agency may ~~is authorized to~~ seek a Medicaid state plan
1894 amendment or federal waiver approval to implement this policy.

1895 (c) The agency may implement a utilization management
1896 program designed to prior-authorize home and community-based
1897 service plans which ~~and~~ includes, but is not limited to,
1898 assessing proposed quantity and duration of services and
1899 monitoring ongoing service use by participants in the program.
1900 The agency may ~~is authorized to~~ competitively procure a
1901 qualified organization to provide utilization management of home
1902 and community-based services. The agency may ~~is authorized to~~
1903 seek any federal waivers to implement this initiative.

1904 (d) The agency shall assess a fee against the parents of a
1905 child who is being served by a waiver under this subsection if
1906 the adjusted household income is greater than 100 percent of the
1907 federal poverty level. The amount of the fee shall be calculated
1908 using a sliding scale based on the size of the family, the
1909 amount of the parent's adjusted gross income, and the federal
1910 poverty guidelines. The agency shall seek a federal waiver to
1911 implement this provision.

1912 (14) HOSPICE CARE SERVICES.—The agency may pay for all
1913 reasonable and necessary services for the palliation or
1914 management of a recipient's terminal illness, if the services

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1915 are provided by a hospice that is licensed under part IV of
1916 chapter 400 and meets Medicare certification requirements.

1917 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY
1918 DISABLED SERVICES.—The agency may pay for health-related care
1919 and services provided on a 24-hour-a-day basis by a facility
1920 licensed and certified as a Medicaid Intermediate Care Facility
1921 for the Developmentally Disabled, for a recipient who needs such
1922 care because of a developmental disability. Payment may ~~shall~~
1923 not include bed-hold days except in facilities with occupancy
1924 rates of 95 percent or greater. The agency may ~~is authorized to~~
1925 seek any federal waiver approvals to implement this policy. If
1926 necessary to safeguard the state's systems of providing services
1927 to elderly and disabled persons and subject to notice and review
1928 under s. 216.177, the Governor may direct the agency to amend
1929 the Medicaid state plan to delete these services.

1930 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for 24-
1931 hour-a-day intermediate care nursing and rehabilitation services
1932 rendered to a recipient in a nursing facility licensed under
1933 part II of chapter 400, if the services are ordered by and
1934 provided under the direction of a physician.

1935 (17) OPTOMETRIC SERVICES.—The agency may pay for services
1936 provided to a recipient, including examination, diagnosis,
1937 treatment, and management, related to ocular pathology, if the
1938 services are provided by a licensed optometrist or physician.

1939 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for
1940 all services provided to a recipient by a physician assistant
1941 licensed under s. 458.347 or s. 459.022. Reimbursement for such
1942 services must be at least ~~not less than~~ 80 percent of the
1943 reimbursement that would be paid to a physician who provided the

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1944 same services.

1945 (19) PODIATRIC SERVICES.—The agency may pay for services,
1946 including diagnosis and medical, surgical, palliative, and
1947 mechanical treatment, related to ailments of the human foot and
1948 lower leg, if provided to a recipient by a podiatric physician
1949 licensed under state law.

1950 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for
1951 medications that are prescribed for a recipient by a physician
1952 or other licensed health care practitioner ~~of the healing arts~~
1953 authorized to prescribe medications and that are dispensed to
1954 the recipient by a licensed pharmacist or physician in
1955 accordance with applicable state and federal law. However, the
1956 agency may not pay for any psychotropic medication prescribed
1957 for a child younger than the age for which the federal Food and
1958 Drug Administration has approved its use.

1959 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency
1960 may pay for all services provided to a recipient by a registered
1961 nurse first assistant as described in s. 464.027. Reimbursement
1962 for such services must be at least ~~may not be less than~~ 80
1963 percent of the reimbursement that would be paid to a physician
1964 providing the same services.

1965 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-
1966 inclusive psychiatric inpatient hospital care provided to a
1967 recipient age 65 or older in a state mental hospital.

1968 (23) VISUAL SERVICES.—The agency may pay for visual
1969 examinations, eyeglasses, and eyeglass repairs for a recipient
1970 if they are prescribed by a licensed physician specializing in
1971 diseases of the eye or by a licensed optometrist. Eyeglass
1972 frames for adult recipients are ~~shall be~~ limited to one pair per

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1973 recipient every 2 years, except a second pair may be provided
1974 ~~during that period~~ after prior authorization. Eyeglass lenses
1975 for adult recipients are ~~shall be~~ limited to one pair per year
1976 except a second pair may be provided ~~during that period~~ after
1977 prior authorization.

1978 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The agency ~~for~~
1979 ~~Health Care Administration~~, in consultation with the Department
1980 of Children and Family Services, may establish a targeted case-
1981 management project in those counties identified by the
1982 department ~~of Children and Family Services~~ and for all counties
1983 with a community-based child welfare project, as authorized
1984 under s. 409.1671, which have been specifically approved by the
1985 department. The covered group that is ~~of individuals who are~~
1986 eligible for ~~to receive~~ targeted case management include
1987 children who are eligible for Medicaid; who are between the ages
1988 of birth through 21; and who are under protective supervision or
1989 postplacement supervision, under foster-care supervision, or in
1990 shelter care or foster care. The number of eligible children
1991 ~~individuals who are eligible to receive targeted case management~~
1992 is limited to the number for whom the department ~~of Children and~~
1993 ~~Family Services~~ has matching funds to cover the costs. The
1994 general revenue funds required to match the funds for services
1995 provided by the community-based child welfare projects are
1996 limited to funds available for services described under s.
1997 409.1671. The department ~~of Children and Family Services~~ may
1998 transfer the general revenue matching funds as billed by the
1999 agency ~~for Health Care Administration~~.

2000 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for
2001 assistive-care services provided to recipients with functional

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2002 or cognitive impairments residing in assisted living facilities,
2003 adult family-care homes, or residential treatment facilities.
2004 These services may include health support, assistance with the
2005 activities of daily living and the instrumental acts of daily
2006 living, assistance with medication administration, and
2007 arrangements for health care.

2008 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM
2009 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency may ~~is~~
2010 ~~authorized to~~ seek federal approval through a Medicaid waiver or
2011 a state plan amendment for the provision of occupational
2012 therapy, speech therapy, physical therapy, behavior analysis,
2013 and behavior assistant services to individuals who are 5 years
2014 of age and under and have a diagnosed developmental disability
2015 as defined in s. 393.063, or autism spectrum disorder as defined
2016 in s. 627.6686, ~~or Down syndrome, a genetic disorder caused by~~
2017 ~~the presence of extra-chromosomal material on chromosome 21.~~
2018 ~~Causes of the syndrome may include Trisomy 21, Mosaicism,~~
2019 ~~Robertsonian Translocation, and other duplications of a portion~~
2020 ~~of chromosome 21.~~ Coverage for such services is ~~shall be~~ limited
2021 to \$36,000 annually and may not exceed \$108,000 in total
2022 lifetime benefits. The agency shall submit an annual report
2023 beginning ~~on~~ January 1, 2009, to the President of the Senate,
2024 the Speaker of the House of Representatives, and the relevant
2025 committees of the Senate and the House of Representatives
2026 regarding progress on obtaining federal approval and
2027 recommendations for the implementation of these home and
2028 community-based services. The agency may not implement this
2029 subsection without prior legislative approval.

2030 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may

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2031 pay for all services provided to a recipient by an
2032 anesthesiologist assistant licensed under s. 458.3475 or s.
2033 459.023. Reimbursement for such services must be at least ~~not~~
2034 ~~less than~~ 80 percent of the reimbursement that would be paid to
2035 a physician who provided the same services.

2036 Section 26. Section 409.9062, Florida Statutes, is amended
2037 to read:

2038 409.9062 Lung transplant services for Medicaid recipients.-
2039 Subject to the availability of funds and ~~subject to~~ any
2040 limitations or directions provided ~~for~~ in the General
2041 Appropriations Act, ~~or~~ chapter 216, or s. 409.9022, the ~~Agency~~
2042 ~~for Health Care Administration~~ Medicaid program shall pay for
2043 medically necessary lung transplant services for Medicaid
2044 recipients. These payments must be used to reimburse approved
2045 lung transplant facilities a global fee for providing lung
2046 transplant services to Medicaid recipients.

2047 Section 27. Paragraph (h) of subsection (3) of section
2048 409.907, Florida Statutes, is amended to read:

2049 409.907 Medicaid provider agreements.-The agency may make
2050 payments for medical assistance and related services rendered to
2051 Medicaid recipients only to an individual or entity who has a
2052 provider agreement in effect with the agency, who is performing
2053 services or supplying goods in accordance with federal, state,
2054 and local law, and who agrees that no person shall, on the
2055 grounds of handicap, race, color, or national origin, or for any
2056 other reason, be subjected to discrimination under any program
2057 or activity for which the provider receives payment from the
2058 agency.

2059 (3) The provider agreement developed by the agency, in

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2060 addition to the requirements specified in subsections (1) and
2061 (2), shall require the provider to:

2062 (h) Be liable for and indemnify, defend, and hold the
2063 agency harmless from all claims, suits, judgments, or damages,
2064 including court costs and attorney's fees, arising out of the
2065 negligence or omissions of the provider in the course of
2066 providing services to a recipient or a person believed to be a
2067 recipient, subject to s. 766.1183 or s. 766.1184.

2068 Section 28. Section 409.908, Florida Statutes, is amended
2069 to read:

2070 409.908 Reimbursement of Medicaid providers.—Subject to
2071 specific appropriations, the agency shall reimburse Medicaid
2072 providers, in accordance with state and federal law, according
2073 to methodologies set forth in the rules of the agency and in
2074 policy manuals and handbooks incorporated by reference therein.
2075 These methodologies may include fee schedules, reimbursement
2076 methods based on cost reporting, negotiated fees, competitive
2077 bidding pursuant to s. 287.057, and other mechanisms the agency
2078 considers efficient and effective for purchasing services or
2079 goods on behalf of recipients. ~~If a provider is reimbursed based
2080 on cost reporting and submits a cost report late and that cost
2081 report would have been used to set a lower reimbursement rate
2082 for a rate semester, then the provider's rate for that semester
2083 shall be retroactively calculated using the new cost report, and
2084 full payment at the recalculated rate shall be effected
2085 retroactively. Medicare granted extensions for filing cost
2086 reports, if applicable, shall also apply to Medicaid cost
2087 reports.~~ Payment for Medicaid compensable services made on
2088 behalf of Medicaid eligible persons is subject to the

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2089 availability of moneys and any limitations or directions
2090 provided ~~for~~ in the General Appropriations Act, ~~or~~ chapter 216,
2091 or s. 409.9022. ~~Further, nothing in~~ This section does not shall
2092 ~~be construed to~~ prevent or limit the agency from adjusting fees,
2093 reimbursement rates, lengths of stay, number of visits, or
2094 number of services, or making any other adjustments necessary to
2095 comply with the availability of moneys and any limitations or
2096 directions provided ~~for~~ in the General Appropriations Act if,
2097 ~~provided~~ the adjustment is consistent with legislative intent.

2098 (1) HOSPITAL SERVICES.—Reimbursement to hospitals licensed
2099 under part I of chapter 395 must be made prospectively or on the
2100 basis of negotiation.

2101 (a) Inpatient care.—

2102 1. Reimbursement for inpatient care is limited as provided
2103 ~~for~~ in s. 409.905(5), except for:

2104 a.1. The raising of rate reimbursement caps, excluding
2105 rural hospitals.

2106 b.2. Recognition of the costs of graduate medical
2107 education.

2108 c.3. Other methodologies recognized in the General
2109 Appropriations Act.

2110 2. ~~During the years~~ funds are transferred from the
2111 Department of Health, any reimbursement supported by such funds
2112 is shall be subject to certification by the Department of Health
2113 that the hospital has complied with s. 381.0403. The agency may
2114 ~~is authorized to~~ receive funds from state entities, including,
2115 but not limited to, the Department of Health, local governments,
2116 and other local political subdivisions, for the purpose of
2117 making special exception payments, including federal matching

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2118 funds, through the Medicaid inpatient reimbursement
 2119 methodologies. Funds received from state entities or local
 2120 governments for this purpose shall be separately accounted for
 2121 and may ~~shall~~ not be commingled with other state or local funds
 2122 in any manner. The agency may certify all local governmental
 2123 funds used as state match under Title XIX of the Social Security
 2124 Act, to the extent that the identified local health care
 2125 provider that is otherwise entitled to and is contracted to
 2126 receive such local funds is the benefactor under the state's
 2127 Medicaid program as determined under the General Appropriations
 2128 Act and pursuant to an agreement between the agency ~~for Health~~
 2129 ~~Care Administration~~ and the local governmental entity. The local
 2130 governmental entity shall use a certification form prescribed by
 2131 the agency. At a minimum, the certification form must ~~shall~~
 2132 identify the amount being certified and describe the
 2133 relationship between the certifying local governmental entity
 2134 and the local health care provider. The agency shall prepare an
 2135 annual statement of impact which documents the specific
 2136 activities undertaken during the previous fiscal year pursuant
 2137 to this paragraph, to be submitted to the Legislature annually
 2138 by no later than January 1, ~~annually.~~

2139 (b) Outpatient care.—

2140 1. Reimbursement for hospital outpatient care is limited to
 2141 \$1,500 per state fiscal year per recipient, except for:

2142 a.1. ~~Such~~ Care provided to a Medicaid recipient under age
 2143 21, in which case the only limitation is medical necessity.

2144 b.2. Renal dialysis services.

2145 c.3. Other exceptions made by the agency.

2146 2. The agency may ~~is authorized to~~ receive funds from state

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2147 entities, including, but not limited to, the Department of
2148 Health, the Board of Governors of the State University System,
2149 local governments, and other local political subdivisions, for
2150 the purpose of making payments, including federal matching
2151 funds, through the Medicaid outpatient reimbursement
2152 methodologies. Funds received ~~from state entities and local~~
2153 ~~governments~~ for this purpose shall be separately accounted for
2154 and may ~~shall~~ not be commingled with other state or local funds
2155 ~~in any manner.~~

2156 3. The agency may limit inflationary increases for
2157 outpatient hospital services as directed by the General
2158 Appropriations Act.

2159 (c) Disproportionate share.—Hospitals that provide services
2160 to a disproportionate share of low-income Medicaid recipients,
2161 ~~or~~ that participate in the regional perinatal intensive care
2162 center program under chapter 383, or that participate in the
2163 statutory teaching hospital disproportionate share program may
2164 receive additional reimbursement. The total amount of payment
2165 for disproportionate share hospitals shall be fixed by the
2166 General Appropriations Act. The computation of these payments
2167 must comply ~~be made in compliance~~ with all federal regulations
2168 and the methodologies described in ss. 409.911, 409.9112, and
2169 409.9113.

2170 ~~(d) The agency is authorized to limit inflationary~~
2171 ~~increases for outpatient hospital services as directed by the~~
2172 ~~General Appropriations Act.~~

2173 (2) NURSING HOME CARE.—

2174 ~~(a)1.~~ Reimbursement to nursing homes licensed under part II
2175 of chapter 400 and state-owned-and-operated intermediate care

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2176 facilities for the developmentally disabled licensed under part
2177 VIII of chapter 400 must be made prospectively.

2178 (a)2. Unless otherwise limited or directed in the General
2179 Appropriations Act, reimbursement to hospitals licensed under
2180 part I of chapter 395 for ~~the provision of~~ swing-bed nursing
2181 home services must based ~~be made on the basis of~~ the average
2182 statewide nursing home payment, and reimbursement to a hospital
2183 ~~licensed under part I of chapter 395 for the provision of~~
2184 skilled nursing services must be based ~~made on the basis of~~ the
2185 average nursing home payment for those services in the county in
2186 which the hospital is located. If ~~When~~ a hospital is located in
2187 a county that does not have any community nursing homes,
2188 reimbursement shall be determined by averaging the nursing home
2189 payments in counties that surround the county in which the
2190 hospital is located. Reimbursement to hospitals, including
2191 Medicaid payment of Medicare copayments, for skilled nursing
2192 services is ~~shall be~~ limited to 30 days, unless a prior
2193 authorization has been obtained from the agency. Medicaid
2194 reimbursement may be extended by the agency beyond 30 days, and
2195 approval must be based upon verification by the patient's
2196 physician that the patient requires short-term rehabilitative
2197 and recuperative services only, in which case an extension of no
2198 more than 15 days may be approved. Reimbursement to a hospital
2199 ~~licensed under part I of chapter 395 for the temporary provision~~
2200 of skilled nursing services to nursing home residents who have
2201 been displaced as the result of a natural disaster or other
2202 emergency may not exceed the average county nursing home payment
2203 for those services in the county in which the hospital is
2204 located and is limited to the period of time which the agency

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2205 considers necessary for continued placement of the nursing home
2206 residents in the hospital.

2207 (b) Subject to any limitations or directions provided ~~for~~
2208 in the General Appropriations Act, the agency shall establish
2209 and implement a Florida Title XIX Long-Term Care Reimbursement
2210 Plan (Medicaid) for nursing home care in order to provide care
2211 and services that conform to ~~in conformance with the~~ applicable
2212 state and federal laws, rules, regulations, and quality and
2213 safety standards and to ensure that individuals eligible for
2214 medical assistance have reasonable geographic access to such
2215 care.

2216 1. The agency shall amend the long-term care reimbursement
2217 plan and cost reporting system to create direct care and
2218 indirect care subcomponents of the patient care component of the
2219 per diem rate. These two subcomponents together must ~~shall~~ equal
2220 the patient care component of the per diem rate. Separate cost-
2221 based ceilings shall be calculated for each patient care
2222 subcomponent. The direct care subcomponent of the per diem rate
2223 is ~~shall be~~ limited by the cost-based class ceiling, and the
2224 indirect care subcomponent may be limited by the lower of the
2225 cost-based class ceiling, the target rate class ceiling, or the
2226 individual provider target.

2227 2. The direct care subcomponent includes ~~shall include~~
2228 salaries and benefits of direct care staff providing nursing
2229 services, including registered nurses, licensed practical
2230 nurses, and certified nursing assistants who deliver care
2231 directly to residents in the nursing home facility. This
2232 excludes nursing administration, minimum data set, and care plan
2233 coordinators, staff development, and the staffing coordinator.

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2234 The direct care subcomponent also includes medically necessary
2235 dental care or podiatric care.

2236 3. All other patient care costs are ~~shall be~~ included in
2237 the indirect care cost subcomponent of the patient care per diem
2238 rate. ~~There shall be no~~ Costs may not be directly or indirectly
2239 allocated to the direct care subcomponent from a home office or
2240 management company.

2241 4. On July 1 of each year, the agency shall report to the
2242 Legislature direct and indirect care costs, including average
2243 direct and indirect care costs per resident per facility and
2244 direct care and indirect care salaries and benefits per category
2245 of staff member per facility.

2246 5. In order to offset the cost of general and professional
2247 liability insurance, the agency shall amend the plan to allow
2248 for interim rate adjustments to reflect increases in the cost of
2249 general or professional liability insurance for nursing homes.
2250 This provision shall be implemented to the extent existing
2251 appropriations are available.

2252
2253 It is the intent of the Legislature that the reimbursement plan
2254 achieve the goal of providing access to health care for nursing
2255 home residents who require large amounts of care while
2256 encouraging diversion services as an alternative to nursing home
2257 care for residents who can be served within the community. The
2258 agency shall base the establishment of any maximum rate of
2259 payment, whether overall or component, on the available moneys
2260 ~~as provided for~~ in the General Appropriations Act. The agency
2261 may base the maximum rate of payment on the results of
2262 scientifically valid analysis and conclusions derived from

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2263 objective statistical data pertinent to the particular maximum
2264 rate of payment.

2265 (c) The agency shall request and implement Medicaid waivers
2266 approved by the federal Centers for Medicare and Medicaid
2267 Services to advance and treat a portion of the Medicaid nursing
2268 home per diem as capital for creating and operating a risk-
2269 retention group for self-insurance purposes, consistent with
2270 federal and state laws and rules.

2271 (3) FEE-FOR-SERVICE REIMBURSEMENT.—Subject to any
2272 limitations or directions provided ~~for~~ in the General
2273 Appropriations Act, the following Medicaid services and goods
2274 may be reimbursed on a fee-for-service basis. For each allowable
2275 service or goods furnished in accordance with Medicaid rules,
2276 policy manuals, handbooks, and state and federal law, the
2277 payment shall be the amount billed by the provider, the
2278 provider's usual and customary charge, or the maximum allowable
2279 fee established by the agency, whichever amount is less, with
2280 the exception of those services or goods for which the agency
2281 makes payment using a methodology based on capitation rates,
2282 average costs, or negotiated fees.

2283 (a) Advanced registered nurse practitioner services.

2284 (b) Birth center services.

2285 (c) Chiropractic services.

2286 (d) Community mental health services.

2287 (e) Dental services, including oral and maxillofacial
2288 surgery.

2289 (f) Durable medical equipment.

2290 (g) Hearing services.

2291 (h) Occupational therapy for Medicaid recipients under age

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- 2292 21.
- 2293 (i) Optometric services.
- 2294 (j) Orthodontic services.
- 2295 (k) Personal care for Medicaid recipients under age 21.
- 2296 (l) Physical therapy for Medicaid recipients under age 21.
- 2297 (m) Physician assistant services.
- 2298 (n) Podiatric services.
- 2299 (o) Portable X-ray services.
- 2300 (p) Private-duty nursing for Medicaid recipients under age
- 2301 21.
- 2302 (q) Registered nurse first assistant services.
- 2303 (r) Respiratory therapy for Medicaid recipients under age
- 2304 21.
- 2305 (s) Speech therapy for Medicaid recipients under age 21.
- 2306 (t) Visual services.
- 2307 (4) MANAGED CARE SERVICES.—Subject to any limitations or
- 2308 directions provided ~~for~~ in the General Appropriations Act,
- 2309 alternative health plans, health maintenance organizations, and
- 2310 prepaid health plans shall be reimbursed a fixed, prepaid amount
- 2311 negotiated, or competitively bid pursuant to s. 287.057, by the
- 2312 agency and prospectively paid to the provider monthly for each
- 2313 Medicaid recipient enrolled. The amount may not exceed the
- 2314 average amount the agency determines it would have paid, based
- 2315 on claims experience, for recipients in the same or similar
- 2316 category of eligibility. The agency shall calculate capitation
- 2317 rates on a regional basis and, ~~beginning September 1, 1995,~~
- 2318 ~~shall~~ include age-band differentials in such calculations.
- 2319 (5) AMBULATORY SURGICAL CENTERS.—An ambulatory surgical
- 2320 center shall be reimbursed the lesser of the amount billed by

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2321 the provider or the Medicare-established allowable amount for
2322 the facility.

2323 (6) EPSDT SERVICES.—A provider of early and periodic
2324 screening, diagnosis, and treatment services to Medicaid
2325 recipients who are ~~children~~ under age 21 shall be reimbursed
2326 using an all-inclusive rate stipulated in a fee schedule
2327 established by the agency. A provider of the visual, dental, and
2328 hearing components of such services shall be reimbursed the
2329 lesser of the amount billed by the provider or the Medicaid
2330 maximum allowable fee established by the agency.

2331 (7) FAMILY PLANNING SERVICES.—A provider of family planning
2332 services shall be reimbursed the lesser of the amount billed by
2333 the provider or an all-inclusive amount per type of visit for
2334 physicians and advanced registered nurse practitioners, as
2335 established by the agency in a fee schedule.

2336 (8) HOME OR COMMUNITY-BASED SERVICES.—A provider of home-
2337 based or community-based services rendered pursuant to a
2338 federally approved waiver shall be reimbursed based on an
2339 established or negotiated rate for each service. These rates
2340 shall be established according to an analysis of the expenditure
2341 history and prospective budget developed by each contract
2342 provider participating in the waiver program, or under any other
2343 methodology adopted by the agency and approved by the Federal
2344 Government in accordance with the waiver. Privately owned and
2345 operated community-based residential facilities that ~~which~~ meet
2346 agency requirements and ~~which~~ formerly received Medicaid
2347 reimbursement for the optional intermediate care facility for
2348 the mentally retarded service may participate in the
2349 developmental services waiver as part of a home-and-community-

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2350 based continuum of care for Medicaid recipients who receive
2351 waiver services.

2352 (9) HOME HEALTH SERVICES AND MEDICAL SUPPLIES.—A provider
2353 of home health care services or of medical supplies and
2354 appliances shall be reimbursed on the basis of competitive
2355 bidding or for the lesser of the amount billed by the provider
2356 or the agency's established maximum allowable amount, except
2357 that, ~~in the case of the rental of durable medical equipment,~~
2358 the total rental payments for durable medical equipment may not
2359 exceed the purchase price of the equipment over its expected
2360 useful life or the agency's established maximum allowable
2361 amount, whichever amount is less.

2362 (10) HOSPICE.—A hospice shall be reimbursed through a
2363 prospective system for each Medicaid hospice patient at Medicaid
2364 rates using the methodology established for hospice
2365 reimbursement pursuant to Title XVIII of the federal Social
2366 Security Act.

2367 (11) LABORATORY SERVICES.—A provider of independent
2368 laboratory services shall be reimbursed on the basis of
2369 competitive bidding or for the least of the amount billed by the
2370 provider, the provider's usual and customary charge, or the
2371 Medicaid maximum allowable fee established by the agency.

2372 (12) PHYSICIAN SERVICES.—

2373 (a) A physician shall be reimbursed the lesser of the
2374 amount billed by the provider or the Medicaid maximum allowable
2375 fee established by the agency.

2376 (b) The agency shall adopt a fee schedule, subject to any
2377 limitations or directions provided ~~for~~ in the General
2378 Appropriations Act, based on a resource-based relative value

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2379 scale for pricing Medicaid physician services. Under the ~~this~~
2380 fee schedule, physicians shall be paid a dollar amount for each
2381 service based on the average resources required to provide the
2382 service, including, but not limited to, estimates of average
2383 physician time and effort, practice expense, and the costs of
2384 professional liability insurance. The fee schedule must ~~shall~~
2385 provide increased reimbursement for preventive and primary care
2386 services and lowered reimbursement for specialty services by
2387 using at least two conversion factors, one for cognitive
2388 services and another for procedural services. The fee schedule
2389 may ~~shall~~ not increase total Medicaid physician expenditures
2390 unless moneys are available. The agency ~~for Health Care~~
2391 ~~Administration~~ shall seek the advice of a 16-member advisory
2392 panel in formulating and adopting the fee schedule. The panel
2393 shall consist of Medicaid physicians licensed under chapters 458
2394 and 459 and ~~shall~~ be composed of 50 percent primary care
2395 physicians and 50 percent specialty care physicians.

2396 (c) Notwithstanding paragraph (b), reimbursement fees to
2397 physicians for providing total obstetrical services to Medicaid
2398 recipients, which include prenatal, delivery, and postpartum
2399 care, must ~~shall~~ be at least \$1,500 per delivery for a pregnant
2400 woman with low medical risk and at least \$2,000 per delivery for
2401 a pregnant woman with high medical risk. However, reimbursement
2402 to physicians working in regional perinatal intensive care
2403 centers designated pursuant to chapter 383, for services to
2404 ~~certain~~ pregnant Medicaid recipients with a high medical risk,
2405 may be made according to obstetrical care and neonatal care
2406 groupings and rates established by the agency. Nurse midwives
2407 licensed under part I of chapter 464 or midwives licensed under

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2408 chapter 467 shall be reimbursed at least ~~no less than~~ 80 percent
2409 of the low medical risk fee. The agency shall by rule determine,
2410 for the purpose of this paragraph, what constitutes a high or
2411 low medical risk pregnant woman and may ~~shall~~ not pay more based
2412 solely on the fact that a caesarean section was performed,
2413 rather than a vaginal delivery. The agency shall by rule
2414 determine a prorated payment for obstetrical services ~~in cases~~
2415 where only part of the total prenatal, delivery, or postpartum
2416 care was performed. The Department of Health shall adopt rules
2417 for appropriate insurance coverage for midwives licensed under
2418 chapter 467. Before issuing and renewing ~~Prior to the issuance~~
2419 ~~and renewal of~~ an active license, or reactivating ~~reactivation~~
2420 ~~of~~ an inactive license for midwives licensed under chapter 467,
2421 such licensees must ~~shall~~ submit proof of coverage with each
2422 application.

2423 (d) Effective January 1, 2013, Medicaid fee-for-service
2424 payments to primary care physicians for primary care services
2425 must be at least 100 percent of the Medicare payment rate for
2426 such services.

2427 (13) DUALLY ELIGIBLE RECIPIENTS.—Medicare premiums for
2428 persons eligible for both Medicare and Medicaid coverage shall
2429 be paid at the rates established by Title XVIII of the Social
2430 Security Act. For Medicare services rendered to Medicaid-
2431 eligible persons, Medicaid shall pay Medicare deductibles and
2432 coinsurance as follows:

2433 (a) Medicaid's financial obligation for deductibles and
2434 coinsurance payments shall be based on Medicare allowable fees,
2435 not on a provider's billed charges.

2436 (b) Medicaid may not ~~will~~ pay any ~~no~~ portion of Medicare

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2437 deductibles and coinsurance if ~~when~~ payment that Medicare has
2438 made for the service equals or exceeds what Medicaid would have
2439 paid if it had been the sole payor. The combined payment of
2440 Medicare and Medicaid may ~~shall~~ not exceed the amount Medicaid
2441 would have paid had it been the sole payor. The Legislature
2442 finds that there has been confusion regarding the reimbursement
2443 for services rendered to dually eligible Medicare beneficiaries.
2444 Accordingly, the Legislature clarifies that it has always been
2445 the intent of the Legislature before and after 1991 that, in
2446 reimbursing in accordance with fees established by Title XVIII
2447 for premiums, deductibles, and coinsurance for Medicare services
2448 rendered by physicians to Medicaid eligible persons, physicians
2449 be reimbursed at the lesser of the amount billed by the
2450 physician or the Medicaid maximum allowable fee established by
2451 the agency ~~for Health Care Administration~~, as is permitted by
2452 federal law. It has never been the intent of the Legislature
2453 ~~with regard to such services rendered by physicians that~~
2454 Medicaid be required to provide any payment for deductibles,
2455 coinsurance, or copayments for Medicare cost sharing, or any
2456 expenses incurred relating thereto, in excess of the payment
2457 amount provided for under the State Medicaid plan for physician
2458 services ~~such service~~. This payment methodology is applicable
2459 even in those situations in which the payment for Medicare cost
2460 sharing for a qualified Medicare beneficiary with respect to an
2461 item or service is reduced or eliminated. This expression of the
2462 Legislature clarifies ~~is in clarification of~~ existing law and
2463 applies ~~shall apply~~ to payment for, and with respect to provider
2464 agreements with respect to, items or services furnished on or
2465 after July 1, 2000 ~~the effective date of this act~~. This

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2466 paragraph applies to payment by Medicaid for items and services
2467 furnished before July 1, 2000, ~~the effective date of this act~~ if
2468 such payment is the subject of a lawsuit that is based on ~~the~~
2469 ~~provisions of~~ this section, and that is pending as of, or is
2470 initiated after that date, ~~the effective date of this act~~.

2471 (c) Notwithstanding paragraphs (a) and (b):

2472 1. Medicaid payments for Nursing Home Medicare part A
2473 coinsurance are limited to the Medicaid nursing home per diem
2474 rate less any amounts paid by Medicare, but only up to the
2475 amount of Medicare coinsurance. The Medicaid per diem rate is
2476 ~~shall be~~ the rate in effect for the dates of service of the
2477 crossover claims and may not be subsequently adjusted due to
2478 subsequent per diem rate adjustments.

2479 2. Medicaid shall pay all deductibles and coinsurance for
2480 Medicare-eligible recipients receiving freestanding end stage
2481 renal dialysis center services.

2482 3. Medicaid payments for general and specialty hospital
2483 inpatient services are limited to the Medicare deductible and
2484 coinsurance per spell of illness. Medicaid payments for hospital
2485 Medicare Part A coinsurance are ~~shall be~~ limited to the Medicaid
2486 hospital per diem rate less any amounts paid by Medicare, but
2487 only up to the amount of Medicare coinsurance. Medicaid payments
2488 for coinsurance are ~~shall be~~ limited to the Medicaid per diem
2489 rate in effect for the dates of service of the crossover claims
2490 and may not be subsequently adjusted due to subsequent per diem
2491 adjustments.

2492 4. Medicaid shall pay all deductibles and coinsurance for
2493 Medicare emergency transportation services provided by
2494 ambulances licensed pursuant to chapter 401.

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2495 5. Medicaid shall pay all deductibles and coinsurance for
2496 portable X-ray Medicare Part B services provided in a nursing
2497 home.

2498 (14) PRESCRIBED DRUGS.—A provider of prescribed drugs shall
2499 be reimbursed the least of the amount billed by the provider,
2500 the provider's usual and customary charge, or the Medicaid
2501 maximum allowable fee established by the agency, plus a
2502 dispensing fee. The Medicaid maximum allowable fee for
2503 ingredient cost must ~~will~~ be based on the lower of the ~~the~~ average
2504 wholesale price (AWP) minus 16.4 percent, wholesaler acquisition
2505 cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the
2506 state maximum allowable cost (SMAC), or the usual and customary
2507 (UAC) charge billed by the provider.

2508 (a) Medicaid providers must ~~are required to~~ dispense
2509 generic drugs if available at lower cost and the agency has not
2510 determined that the branded product is more cost-effective,
2511 unless the prescriber has requested and received approval to
2512 require the branded product.

2513 (b) The agency shall ~~is directed to~~ implement a variable
2514 dispensing fee for ~~payments for~~ prescribed medicines while
2515 ensuring continued access for Medicaid recipients. The variable
2516 dispensing fee may be based upon, but not limited to, either or
2517 both the volume of prescriptions dispensed by a specific
2518 pharmacy provider, the volume of prescriptions dispensed to an
2519 individual recipient, and dispensing of preferred-drug-list
2520 products.

2521 (c) The agency may increase the pharmacy dispensing fee
2522 authorized by statute and in the ~~annual~~ General Appropriations
2523 Act by \$0.50 for the dispensing of a Medicaid preferred-drug-

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2524 list product and reduce the pharmacy dispensing fee by \$0.50 for
2525 the dispensing of a Medicaid product that is not included on the
2526 preferred drug list.

2527 (d) The agency may establish a supplemental pharmaceutical
2528 dispensing fee to be paid to providers returning unused unit-
2529 dose packaged medications to stock and crediting the Medicaid
2530 program for the ingredient cost of those medications if the
2531 ingredient costs to be credited exceed the value of the
2532 supplemental dispensing fee.

2533 (e) The agency may ~~is authorized to~~ limit reimbursement for
2534 prescribed medicine in order to comply with any limitations or
2535 directions provided ~~for~~ in the General Appropriations Act, which
2536 may include implementing a prospective or concurrent utilization
2537 review program.

2538 (15) PRIMARY CARE CASE MANAGEMENT.—A provider of primary
2539 care case management services rendered pursuant to a federally
2540 approved waiver shall be reimbursed by payment of a fixed,
2541 prepaid monthly sum for each Medicaid recipient enrolled with
2542 the provider.

2543 (16) RURAL HEALTH CLINICS.—A provider of rural health
2544 clinic services and federally qualified health center services
2545 shall be reimbursed a rate per visit based on total reasonable
2546 costs of the clinic, as determined by the agency in accordance
2547 with federal regulations.

2548 (17) TARGETED CASE MANAGEMENT.—A provider of targeted case
2549 management services shall be reimbursed pursuant to an
2550 established fee, except where the Federal Government requires a
2551 public provider be reimbursed on the basis of average actual
2552 costs.

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2553 (18) TRANSPORTATION.—Unless otherwise provided ~~for~~ in the
2554 General Appropriations Act, a provider of transportation
2555 services shall be reimbursed the lesser of the amount billed by
2556 the provider or the Medicaid maximum allowable fee established
2557 by the agency, except if ~~when~~ the agency has entered into a
2558 direct contract with the provider, or with a community
2559 transportation coordinator, for the provision of an all-
2560 inclusive service, or if ~~when~~ services are provided pursuant to
2561 an agreement negotiated between the agency and the provider. ~~The~~
2562 ~~agency, as provided for in s. 427.0135, shall purchase~~
2563 ~~transportation services through the community coordinated~~
2564 ~~transportation system, if available, unless the agency, after~~
2565 ~~consultation with the commission, determines that it cannot~~
2566 ~~reach mutually acceptable contract terms with the commission.~~
2567 ~~The agency may then contract for the same transportation~~
2568 ~~services provided in a more cost-effective manner and of~~
2569 ~~comparable or higher quality and standards. Nothing in~~

2570 (a) This subsection does not ~~shall be construed to~~ limit or
2571 preclude the agency from contracting for services using a
2572 prepaid capitation rate or from establishing maximum fee
2573 schedules, individualized reimbursement policies by provider
2574 type, negotiated fees, prior authorization, competitive bidding,
2575 increased use of mass transit, or any other mechanism that the
2576 agency considers efficient and effective for the purchase of
2577 services on behalf of Medicaid clients, including implementing a
2578 transportation eligibility process.

2579 (b) The agency may ~~shall~~ not ~~be required to~~ contract with
2580 any community transportation coordinator or transportation
2581 operator that has been determined by the agency, the Department

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2582 of Legal Affairs Medicaid Fraud Control Unit, or any other state
2583 or federal agency to have engaged in any abusive or fraudulent
2584 billing activities.

2585 (c) The agency shall ~~is authorized to~~ competitively procure
2586 transportation services or make other changes necessary to
2587 secure approval of federal waivers needed to permit federal
2588 financing of Medicaid transportation services at the service
2589 matching rate rather than the administrative matching rate.
2590 ~~Notwithstanding chapter 427, the agency is authorized to~~
2591 ~~continue contracting for Medicaid nonemergency transportation~~
2592 ~~services in agency service area 11 with managed care plans that~~
2593 ~~were under contract for those services before July 1, 2004.~~

2594 (d) Transportation to access covered services provided by a
2595 qualified plan pursuant to part IV of this chapter shall be
2596 contracted for by the plan. A qualified plan is not required to
2597 purchase such services through a coordinated transportation
2598 system established pursuant to part I of chapter 427.

2599 (19) COUNTY HEALTH DEPARTMENTS.—County health department
2600 services shall be reimbursed a rate per visit based on total
2601 reasonable costs of the clinic, as determined by the agency in
2602 accordance with federal regulations under the authority of 42
2603 C.F.R. s. 431.615.

2604 (20) DIALYSIS.—A renal dialysis facility that provides
2605 dialysis services under s. 409.906(9) must be reimbursed the
2606 lesser of the amount billed by the provider, the provider's
2607 usual and customary charge, or the maximum allowable fee
2608 established by the agency, whichever ~~amount~~ is less.

2609 (21) SCHOOL-BASED SERVICES.—The agency shall reimburse
2610 school districts that ~~which~~ certify the state match pursuant to

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2611 ss. 409.9071 and 1011.70 for the federal portion of the school
2612 district's allowable costs to deliver the services, based on the
2613 reimbursement schedule. The school district shall determine the
2614 costs for delivering services as authorized in ss. 409.9071 and
2615 1011.70 for which the state match will be certified.

2616 Reimbursement of school-based providers is contingent on such
2617 providers being enrolled as Medicaid providers and meeting the
2618 qualifications contained in 42 C.F.R. s. 440.110, unless
2619 otherwise waived by the federal Centers for Medicare and
2620 Medicaid Services Health Care Financing Administration. Speech
2621 therapy providers who are certified through the Department of
2622 Education pursuant to rule 6A-4.0176, Florida Administrative
2623 Code, are eligible for reimbursement for services that are
2624 provided on school premises. Any employee of the school district
2625 who has been fingerprinted and has received a criminal
2626 background check in accordance with Department of Education
2627 rules and guidelines is ~~shall be~~ exempt from any agency
2628 requirements relating to criminal background checks.

2629 ~~(22) The agency shall request and implement Medicaid~~
2630 ~~waivers from the federal Health Care Financing Administration to~~
2631 ~~advance and treat a portion of the Medicaid nursing home per~~
2632 ~~diem as capital for creating and operating a risk retention~~
2633 ~~group for self insurance purposes, consistent with federal and~~
2634 ~~state laws and rules.~~

2635 (22)-(23) (a) LIMITATION ON REIMBURSEMENT RATES.—The agency
2636 shall establish rates at a level that ensures no increase in
2637 statewide expenditures resulting from a change in unit costs for
2638 2 fiscal years effective July 1, 2009. Reimbursement rates for
2639 the 2 fiscal years shall be as provided in the General

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2640 Appropriations Act.

2641 (a)~~(b)~~ This subsection applies to the following provider
2642 types:

- 2643 1. Inpatient hospitals.
- 2644 2. Outpatient hospitals.
- 2645 3. Nursing homes.
- 2646 4. County health departments.
- 2647 5. Community intermediate care facilities for the
2648 developmentally disabled.
- 2649 6. Prepaid health plans.

2650 (b) The agency shall apply ~~the effect of~~ this subsection to
2651 the reimbursement rates for nursing home diversion programs.

2652 ~~(c) The agency shall create a workgroup on hospital
2653 reimbursement, a workgroup on nursing facility reimbursement,
2654 and a workgroup on managed care plan payment. The workgroups
2655 shall evaluate alternative reimbursement and payment
2656 methodologies for hospitals, nursing facilities, and managed
2657 care plans, including prospective payment methodologies for
2658 hospitals and nursing facilities. The nursing facility workgroup
2659 shall also consider price-based methodologies for indirect care
2660 and acuity adjustments for direct care. The agency shall submit
2661 a report on the evaluated alternative reimbursement
2662 methodologies to the relevant committees of the Senate and the
2663 House of Representatives by November 1, 2009.~~

2664 (c)~~(d)~~ This subsection expires June 30, 2011.

2665 (23) PAYMENT METHODOLOGIES.—If a provider is reimbursed
2666 based on cost reporting and submits a cost report late and that
2667 cost report would have been used to set a lower reimbursement
2668 rate for a rate semester, the provider's rate for that semester

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2669 shall be retroactively calculated using the new cost report, and
2670 full payment at the recalculated rate shall be applied
2671 retroactively. Medicare-granted extensions for filing cost
2672 reports, if applicable, also apply to Medicaid cost reports.

2673 (24) RETURN OF PAYMENTS.—If a provider fails to notify the
2674 agency within 5 business days after suspension or disenrollment
2675 from Medicare, sanctions may be imposed pursuant to this
2676 chapter, and the provider may be required to return funds paid
2677 to the provider during the period of time that the provider was
2678 suspended or disenrolled ~~as a Medicare provider.~~

2679 Section 29. Subsection (1) of section 409.9081, Florida
2680 Statutes, is amended to read:

2681 409.9081 Copayments.—

2682 (1) ~~The agency shall require,~~ Subject to federal
2683 regulations and limitations, each Medicaid recipient must ~~to~~ pay
2684 at the time of service a nominal copayment for the following
2685 Medicaid services:

2686 (a) Hospital outpatient services: up to \$3 for each
2687 hospital outpatient visit.

2688 (b) Physician services: up to \$2 copayment for each visit
2689 with a primary care physician and up to \$3 copayment for each
2690 visit with a specialty care physician licensed under chapter
2691 ~~458, chapter 459, chapter 460, chapter 461, or chapter 463.~~

2692 (c) Hospital emergency department visits for nonemergency
2693 care: 5 percent of up to the first \$300 of the Medicaid payment
2694 for emergency room services, not to exceed \$15. The agency shall
2695 seek a federal waiver of the requirement that cost-sharing
2696 amounts for nonemergency services and care furnished in a
2697 hospital emergency department be nominal. Upon waiver approval,

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2698 a Medicaid recipient who requests such services and care, must
2699 pay a \$100 copayment to the hospital for the nonemergency
2700 services and care provided in the hospital emergency department.

2701 (d) Prescription drugs: a coinsurance equal to 2.5 percent
2702 of the Medicaid cost of the prescription drug at the time of
2703 purchase. The maximum coinsurance is ~~shall be~~ \$7.50 per
2704 prescription drug purchased.

2705 Section 30. Paragraph (b) and (d) of subsection (4) and
2706 subsections (8), (34), (44), (47), and (53) of section 409.912,
2707 Florida Statutes, are amended, and subsections (48) through (52)
2708 of that section are renumbered as subsections (47) through (51)
2709 respectively, to read:

2710 409.912 Cost-effective purchasing of health care.—The
2711 agency shall purchase goods and services for Medicaid recipients
2712 in the most cost-effective manner consistent with the delivery
2713 of quality medical care. To ensure that medical services are
2714 effectively utilized, the agency may, in any case, require a
2715 confirmation or second physician's opinion of the correct
2716 diagnosis for purposes of authorizing future services under the
2717 Medicaid program. This section does not restrict access to
2718 emergency services or poststabilization care services as defined
2719 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2720 shall be rendered in a manner approved by the agency. The agency
2721 shall maximize the use of prepaid per capita and prepaid
2722 aggregate fixed-sum basis services when appropriate and other
2723 alternative service delivery and reimbursement methodologies,
2724 including competitive bidding pursuant to s. 287.057, designed
2725 to facilitate the cost-effective purchase of a case-managed
2726 continuum of care. The agency shall also require providers to

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2727 minimize the exposure of recipients to the need for acute
2728 inpatient, custodial, and other institutional care and the
2729 inappropriate or unnecessary use of high-cost services. The
2730 agency shall contract with a vendor to monitor and evaluate the
2731 clinical practice patterns of providers in order to identify
2732 trends that are outside the normal practice patterns of a
2733 provider's professional peers or the national guidelines of a
2734 provider's professional association. The vendor must be able to
2735 provide information and counseling to a provider whose practice
2736 patterns are outside the norms, in consultation with the agency,
2737 to improve patient care and reduce inappropriate utilization.
2738 The agency may mandate prior authorization, drug therapy
2739 management, or disease management participation for certain
2740 populations of Medicaid beneficiaries, certain drug classes, or
2741 particular drugs to prevent fraud, abuse, overuse, and possible
2742 dangerous drug interactions. The Pharmaceutical and Therapeutics
2743 Committee shall make recommendations to the agency on drugs for
2744 which prior authorization is required. The agency shall inform
2745 the Pharmaceutical and Therapeutics Committee of its decisions
2746 regarding drugs subject to prior authorization. The agency is
2747 authorized to limit the entities it contracts with or enrolls as
2748 Medicaid providers by developing a provider network through
2749 provider credentialing. The agency may competitively bid single-
2750 source-provider contracts if procurement of goods or services
2751 results in demonstrated cost savings to the state without
2752 limiting access to care. The agency may limit its network based
2753 on the assessment of beneficiary access to care, provider
2754 availability, provider quality standards, time and distance
2755 standards for access to care, the cultural competence of the

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2756 provider network, demographic characteristics of Medicaid
2757 beneficiaries, practice and provider-to-beneficiary standards,
2758 appointment wait times, beneficiary use of services, provider
2759 turnover, provider profiling, provider licensure history,
2760 previous program integrity investigations and findings, peer
2761 review, provider Medicaid policy and billing compliance records,
2762 clinical and medical record audits, and other factors. Providers
2763 shall not be entitled to enrollment in the Medicaid provider
2764 network. The agency shall determine instances in which allowing
2765 Medicaid beneficiaries to purchase durable medical equipment and
2766 other goods is less expensive to the Medicaid program than long-
2767 term rental of the equipment or goods. The agency may establish
2768 rules to facilitate purchases in lieu of long-term rentals in
2769 order to protect against fraud and abuse in the Medicaid program
2770 as defined in s. 409.913. The agency may seek federal waivers
2771 necessary to administer these policies.

2772 (4) The agency may contract with:

2773 (b) An entity that is providing comprehensive behavioral
2774 health care services to ~~certain~~ Medicaid recipients through a
2775 capitated, prepaid arrangement pursuant to the federal waiver
2776 authorized under s. 409.905(5)(b) ~~provided for by s. 409.905(5)~~.
2777 Such entity must be licensed under chapter 624, chapter 636, or
2778 chapter 641, or authorized under paragraph (c) or paragraph (d),
2779 and must possess the clinical systems and operational competence
2780 to manage risk and provide comprehensive behavioral health care
2781 to Medicaid recipients. As used in this paragraph, the term
2782 "comprehensive behavioral health care services" means covered
2783 mental health and substance abuse treatment services that are
2784 available to Medicaid recipients. The Secretary ~~of the~~

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2785 Department of Children and Family Services must ~~shall~~ approve
2786 ~~provisions of~~ procurements related to children in the
2787 department's care or custody before enrolling such children in a
2788 prepaid behavioral health plan. Any contract awarded under this
2789 paragraph must be competitively procured. ~~In developing~~ The
2790 behavioral health care prepaid plan procurement document must
2791 require, ~~the agency shall ensure that the procurement document~~
2792 ~~requires~~ the contractor to develop and implement a plan to
2793 ensure compliance with s. 394.4574 related to services provided
2794 to residents of licensed assisted living facilities that hold a
2795 limited mental health license. Except as provided in
2796 subparagraph 5. 8., and except in counties where the Medicaid
2797 managed care pilot program is authorized pursuant to s. 409.986
2798 ~~409.91211~~, the agency shall seek federal approval to contract
2799 with a single entity ~~meeting these requirements~~ to provide
2800 comprehensive behavioral health care services to all Medicaid
2801 recipients not enrolled in a Medicaid managed care plan
2802 authorized under s. 409.986 ~~409.91211~~, a provider service
2803 network authorized under paragraph (d), or a Medicaid health
2804 maintenance organization in an AHCA area. In an AHCA area where
2805 the Medicaid managed care pilot program is authorized pursuant
2806 to s. 409.986 ~~409.91211~~ in one or more counties, the agency may
2807 procure a contract with a single entity to serve the remaining
2808 counties as an AHCA area or the remaining counties may be
2809 included with an adjacent AHCA area and are subject to this
2810 paragraph. Each entity must offer a ~~sufficient~~ choice of
2811 providers in its network to ensure recipient access to care and
2812 the opportunity to select a provider with whom they are
2813 satisfied. The network shall include all public mental health

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2814 hospitals. To ensure unimpaired access to behavioral health care
2815 services by Medicaid recipients, all contracts issued pursuant
2816 to this paragraph must require that 90 ~~80~~ percent of the
2817 capitation paid to the managed care plan, including health
2818 maintenance organizations and capitated provider service
2819 networks, ~~to~~ be expended for the provision of behavioral health
2820 care services. If the managed care plan expends less than 90 ~~80~~
2821 percent ~~of the capitation paid~~ for the provision of behavioral
2822 health care services, the difference shall be returned to the
2823 agency. The agency shall provide the plan with a certification
2824 letter indicating the amount of capitation paid during each
2825 calendar year for behavioral health care services pursuant to
2826 this section. The agency may reimburse ~~for~~ substance abuse
2827 treatment services on a fee-for-service basis until the agency
2828 finds that adequate funds are available for capitated, prepaid
2829 arrangements.

2830 1. ~~By January 1, 2001,~~ The agency shall modify the
2831 contracts with the entities providing comprehensive inpatient
2832 and outpatient mental health care services to Medicaid
2833 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
2834 Counties, to include substance abuse treatment services.

2835 2. ~~By July 1, 2003, the agency and the Department of~~
2836 ~~Children and Family Services shall execute a written agreement~~
2837 ~~that requires collaboration and joint development of all policy,~~
2838 ~~budgets, procurement documents, contracts, and monitoring plans~~
2839 ~~that have an impact on the state and Medicaid community mental~~
2840 ~~health and targeted case management programs.~~

2841 2.3. Except as provided in subparagraph 5. 8., ~~by July 1,~~
2842 ~~2006,~~ the agency and the Department of Children and Family

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2843 Services shall contract with managed care entities in each AHCA
2844 area ~~except area 6~~ or arrange to provide comprehensive inpatient
2845 and outpatient mental health and substance abuse services
2846 through capitated prepaid arrangements to all Medicaid
2847 recipients who are eligible to participate in such plans under
2848 federal law and regulation. In AHCA areas where there are fewer
2849 than 150,000 eligible individuals ~~number less than 150,000~~, the
2850 agency shall contract with a single managed care plan to provide
2851 comprehensive behavioral health services to all recipients who
2852 are not enrolled in a Medicaid health maintenance organization,
2853 a provider service network authorized under paragraph (d), or a
2854 Medicaid capitated managed care plan authorized under s. 409.986
2855 ~~409.91211~~. The agency may contract with more than one
2856 comprehensive behavioral health provider to provide care to
2857 recipients who are not enrolled in a Medicaid capitated managed
2858 care plan authorized under s. 409.986 ~~409.91211~~, a provider
2859 service network authorized under paragraph (d), or a Medicaid
2860 health maintenance organization in AHCA areas where the eligible
2861 population exceeds 150,000. In an AHCA area where the Medicaid
2862 managed care pilot program is authorized pursuant to s. 409.986
2863 ~~409.91211~~ in one or more counties, the agency may procure a
2864 contract with a single entity to serve the remaining counties as
2865 an AHCA area or the remaining counties may be included with an
2866 adjacent AHCA area and shall be subject to this paragraph.
2867 Contracts for comprehensive behavioral health providers awarded
2868 pursuant to this section must ~~shall~~ be competitively procured.
2869 Both for-profit and not-for-profit corporations are eligible to
2870 compete. Managed care plans contracting with the agency under
2871 subsection (3) or paragraph (d), shall provide and receive

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2872 payment for the same comprehensive behavioral health benefits as
2873 provided in AHCA rules, including handbooks incorporated by
2874 reference. In AHCA area 11, the agency shall contract with at
2875 least two comprehensive behavioral health care providers to
2876 provide behavioral health care to recipients ~~in that area~~ who
2877 are enrolled in, or assigned to, the MediPass program. One of
2878 the ~~behavioral health care~~ contracts must be with the existing
2879 provider service network pilot project, as described in
2880 paragraph (d), for the purpose of demonstrating the cost-
2881 effectiveness of the provision of quality mental health services
2882 through a public hospital-operated managed care model. Payment
2883 shall be at an agreed-upon capitated rate to ensure cost
2884 savings. Of the recipients in area 11 who are assigned to
2885 MediPass ~~under s. 409.9122(2)(k)~~, a minimum of 50,000 of those
2886 MediPass-enrolled recipients shall be assigned to the existing
2887 provider service network in area 11 for their behavioral care.

2888 ~~4. By October 1, 2003, the agency and the department shall~~
2889 ~~submit a plan to the Governor, the President of the Senate, and~~
2890 ~~the Speaker of the House of Representatives which provides for~~
2891 ~~the full implementation of capitated prepaid behavioral health~~
2892 ~~care in all areas of the state.~~

2893 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
2894 ~~of the state where the agency is able to establish sufficient~~
2895 ~~capitation rates.~~

2896 ~~b. If the agency determines that the proposed capitation~~
2897 ~~rate in any area is insufficient to provide appropriate~~
2898 ~~services, the agency may adjust the capitation rate to ensure~~
2899 ~~that care will be available. The agency and the department may~~
2900 ~~use existing general revenue to address any additional required~~

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2901 ~~match but may not over-obligate existing funds on an annualized~~
2902 ~~basis.~~

2903 ~~e. Subject to any limitations provided in the General~~
2904 ~~Appropriations Act, the agency, in compliance with appropriate~~
2905 ~~federal authorization, shall develop policies and procedures~~
2906 ~~that allow for certification of local and state funds.~~

2907 3.5. Children residing in a statewide inpatient psychiatric
2908 program, or in a Department of Juvenile Justice or a Department
2909 of Children and Family Services residential program approved as
2910 a Medicaid behavioral health overlay services provider may not
2911 be included in a behavioral health care prepaid health plan or
2912 any other Medicaid managed care plan pursuant to this paragraph.

2913 ~~6. In converting to a prepaid system of delivery, the~~
2914 ~~agency shall in its procurement document require an entity~~
2915 ~~providing only comprehensive behavioral health care services to~~
2916 ~~prevent the displacement of indigent care patients by enrollees~~
2917 ~~in the Medicaid prepaid health plan providing behavioral health~~
2918 ~~care services from facilities receiving state funding to provide~~
2919 ~~indigent behavioral health care, to facilities licensed under~~
2920 ~~chapter 395 which do not receive state funding for indigent~~
2921 ~~behavioral health care, or reimburse the unsubsidized facility~~
2922 ~~for the cost of behavioral health care provided to the displaced~~
2923 ~~indigent care patient.~~

2924 4.7. Traditional community mental health providers under
2925 contract with the Department of Children and Family Services
2926 pursuant to part IV of chapter 394, ~~child welfare providers~~
2927 ~~under contract with the Department of Children and Family~~
2928 ~~Services in areas 1 and 6,~~ and inpatient mental health providers
2929 licensed pursuant to chapter 395 must be offered an opportunity

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2930 to accept or decline a contract to participate in any provider
2931 network for prepaid behavioral health services.

2932 ~~5.8.~~ All Medicaid-eligible children, except children in
2933 area 1 and children in ~~Highlands County, Hardee County, Polk~~
2934 ~~County, or Manatee County~~ in ~~of~~ area 6, whose cases ~~that~~ are
2935 open for child welfare services in the statewide automated child
2936 welfare information HomeSafeNet system, shall receive their
2937 behavioral health care services through a specialty prepaid plan
2938 operated by community-based lead agencies through a single
2939 agency or formal agreements among several agencies. The
2940 specialty prepaid plan must result in savings to the state
2941 comparable to savings achieved in other Medicaid managed care
2942 and prepaid programs. Such plan must provide mechanisms to
2943 maximize state and local revenues. The specialty prepaid plan
2944 shall be developed by the agency and the Department of Children
2945 and Family Services. The agency may seek federal waivers to
2946 implement this initiative. Medicaid-eligible children whose
2947 cases are open for child welfare services in the statewide
2948 automated child welfare information HomeSafeNet system and who
2949 reside in AHCA area 10 shall be enrolled in capitated managed
2950 care plans that, in coordination with available community-based
2951 care providers specified in s. 409.1671, provide sufficient
2952 medical, developmental, behavioral, and emotional services to
2953 meet the needs of these children, subject to funding as provided
2954 in the General Appropriations Act ~~are exempt from the specialty~~
2955 ~~prepaid plan upon the development of a service delivery~~
2956 ~~mechanism for children who reside in area 10 as specified in s.~~
2957 ~~409.91211(3)(dd).~~

2958 (d) A provider service network, which may be reimbursed on

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2959 a fee-for-service or prepaid basis.

2960 1. A provider service network ~~that~~ ~~which~~ is reimbursed by
2961 the agency on a prepaid basis ~~is shall be~~ exempt from parts I
2962 and III of chapter 641, but must comply with the solvency
2963 requirements in s. 641.2261(2) and meet appropriate financial
2964 reserve, quality assurance, and patient rights requirements ~~as~~
2965 established by the agency.

2966 2. ~~Medicaid recipients assigned to a provider service~~
2967 ~~network shall be chosen equally from those who would otherwise~~
2968 ~~have been assigned to prepaid plans and MediPass. The agency may~~
2969 ~~is authorized to seek federal Medicaid waivers as necessary to~~
2970 ~~implement the provisions of this section. Any contract~~
2971 ~~previously awarded to a provider service network operated by a~~
2972 ~~hospital pursuant to this subsection shall remain in effect for~~
2973 ~~a period of 3 years following the current contract expiration~~
2974 ~~date, regardless of any contractual provisions to the contrary.~~

2975 3. A provider service network is a network established or
2976 organized and operated by a health care provider, or group of
2977 affiliated health care providers, including minority physician
2978 networks and emergency room diversion programs that meet the
2979 requirements of s. 409.986 ~~409.91211~~, which provides a
2980 substantial proportion of the health care items and services
2981 under a contract directly through the provider or affiliated
2982 group of providers and may make arrangements with physicians or
2983 other health care professionals, health care institutions, or
2984 any combination of such individuals or institutions to assume
2985 all or part of the financial risk on a prospective basis for the
2986 provision of basic health services by the physicians, by other
2987 health professionals, or through the institutions. The health

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2988 care providers must have a controlling interest in the governing
2989 body of the provider service network organization.

2990 (8) ~~(a)~~ The agency may contract on a prepaid or fixed-sum
2991 basis with an exclusive provider organization to provide health
2992 care services to Medicaid recipients if provided that the
2993 exclusive provider organization meets applicable managed care
2994 plan requirements in this section, ss. 409.987, 409.988
2995 ~~409.9122, 409.9123,~~ 409.9128, and 627.6472, and other applicable
2996 provisions of law.

2997 ~~(b) For a period of no longer than 24 months after the~~
2998 ~~effective date of this paragraph, when a member of an exclusive~~
2999 ~~provider organization that is contracted by the agency to~~
3000 ~~provide health care services to Medicaid recipients in rural~~
3001 ~~areas without a health maintenance organization obtains services~~
3002 ~~from a provider that participates in the Medicaid program in~~
3003 ~~this state, the provider shall be paid in accordance with the~~
3004 ~~appropriate fee schedule for services provided to eligible~~
3005 ~~Medicaid recipients. The agency may seek waiver authority to~~
3006 ~~implement this paragraph.~~

3007 (34) The agency and entities that contract with the agency
3008 to provide health care services to Medicaid recipients under
3009 this section or ss. 409.986 and 409.987 ~~409.91211 and 409.9122~~
3010 must comply with the provisions of s. 641.513 in providing
3011 emergency services and care to Medicaid recipients and MediPass
3012 recipients. Where feasible, safe, and cost-effective, the agency
3013 shall encourage hospitals, emergency medical services providers,
3014 and other public and private health care providers to work
3015 together in their local communities to enter into agreements or
3016 arrangements to ensure access to alternatives to emergency

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3017 services and care for those Medicaid recipients who need
3018 nonemergent care. The agency shall coordinate with hospitals,
3019 emergency medical services providers, private health plans,
3020 capitated managed care networks as established in s. 409.986
3021 ~~409.91211~~, and other public and private health care providers to
3022 implement the provisions of ss. 395.1041(7), 409.91255(3)(g),
3023 627.6405, and 641.31097 to develop and implement emergency
3024 department diversion programs for Medicaid recipients.

3025 (44) The agency ~~for Health Care Administration~~ shall ensure
3026 that any Medicaid managed care plan as defined in s.
3027 409.987(2)(f) ~~409.9122(2)(f)~~, whether paid on a capitated basis
3028 or a shared savings basis, is cost-effective. For purposes of
3029 this subsection, the term "cost-effective" means that a
3030 network's per-member, per-month costs to the state, including,
3031 but not limited to, fee-for-service costs, administrative costs,
3032 and case-management fees, if any, must be no greater than the
3033 state's costs associated with contracts for Medicaid services
3034 established under subsection (3), which may be adjusted for
3035 health status. The agency shall conduct actuarially sound
3036 adjustments for health status in order to ensure such cost-
3037 effectiveness and shall annually publish the results on its
3038 Internet website. Contracts established pursuant to this
3039 subsection which are not cost-effective may not be renewed.

3040 ~~(47) The agency shall conduct a study of available~~
3041 ~~electronic systems for the purpose of verifying the identity and~~
3042 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
3043 ~~to the Legislature a plan to implement an electronic~~
3044 ~~verification system for Medicaid recipients by January 31, 2005.~~

3045 ~~(53) Before seeking an amendment to the state plan for~~

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3046 ~~purposes of implementing programs authorized by the Deficit~~
3047 ~~Reduction Act of 2005, the agency shall notify the Legislature.~~

3048 Section 31. Paragraph (a) of subsection (1) of section
3049 409.915, Florida Statutes, is amended to read:

3050 409.915 County contributions to Medicaid.—Although the
3051 state is responsible for the full portion of the state share of
3052 the matching funds required for the Medicaid program, in order
3053 to acquire a certain portion of these funds, the state shall
3054 charge the counties for certain items of care and service as
3055 provided in this section.

3056 (1) Each county shall participate in the following items of
3057 care and service:

3058 (a) For both health maintenance members and fee-for-service
3059 beneficiaries, payments for inpatient hospitalization in excess
3060 of 10 days, but not in excess of 45 days, with the exception of
3061 pregnant women and children whose income is greater than ~~in~~
3062 ~~excess of~~ the federal poverty level and who do not receive a
3063 Medicaid nonpoverty medical subsidy ~~participate in the Medicaid~~
3064 ~~medically needy Program~~, and for adult lung transplant services.

3065 Section 32. Section 409.9301, Florida Statutes, is
3066 transferred, renumbered as section 409.9067, Florida Statutes,
3067 and subsections (1) and (2) of that section are amended, to
3068 read:

3069 409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—

3070 (1) PROGRAM ESTABLISHED.—A program is established in the
3071 agency ~~for Health Care Administration~~ to provide pharmaceutical
3072 expense assistance to individuals diagnosed with cancer or
3073 individuals who have obtained ~~received~~ organ transplants who
3074 received a Medicaid nonpoverty medical subsidy before ~~were~~

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3075 ~~medically needy recipients prior to~~ January 1, 2006.

3076 (2) ELIGIBILITY.—Eligibility for the program is limited to
3077 an individual who:

3078 (a) Is a resident of this state;

3079 (b) Was a Medicaid recipient who received a nonpoverty
3080 medical subsidy before ~~under the Florida Medicaid medically~~
3081 ~~needy program prior to~~ January 1, 2006;

3082 (c) Is eligible for Medicare;

3083 (d) Is a cancer patient or an organ transplant recipient;

3084 and

3085 (e) Requests to be enrolled in the program.

3086 Section 33. Subsection (1) of section 409.9126, Florida
3087 Statutes, is amended to read:

3088 409.9126 Children with special health care needs.—

3089 (1) Except as provided in subsection (4), children eligible
3090 for Children's Medical Services who receive Medicaid benefits,
3091 and other Medicaid-eligible children with special health care
3092 needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.987
3093 ~~409.9122~~ and shall be served through the Children's Medical
3094 Services network established in chapter 391.

3095 Section 34. The Division of Statutory Revision is requested
3096 to create part IV of chapter 409, Florida Statutes, consisting
3097 of sections 409.961-409.978, Florida Statutes, entitled
3098 "MEDICAID MANAGED CARE."

3099 Section 35. Section 409.961, Florida Statutes, is created
3100 to read:

3101 409.961 Construction; applicability.—It is the intent of
3102 the Legislature that if any conflict exists between ss. 409.961-
3103 409.978 and other parts or sections of this chapter, the

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3104 provisions in ss. 409.961-409.978 control. Sections 409.961-
3105 409.978 apply only to the Medicaid managed care program, as
3106 provided in this part.

3107 Section 36. Section 409.962, Florida Statutes, is created
3108 to read:

3109 409.962 Definitions.—As used in this part, and including
3110 the terms defined in s. 409.901, the term:

3111 (1) "Direct care management" means care management
3112 activities that involve direct interaction between providers and
3113 patients.

3114 (2) "Medicaid managed care program" means the integrated,
3115 statewide Medicaid program created in this part, which includes
3116 the provision of managed care medical assistance services
3117 described in ss. 409.971 and 409.972 and managed long-term care
3118 services described in ss. 409.973-409.978.

3119 (3) "Provider service network" means an entity of which a
3120 controlling interest is owned by a health care provider, a group
3121 of affiliated providers, or a public agency or entity that
3122 delivers health services. Health care providers include Florida-
3123 licensed health care professionals or licensed health care
3124 facilities, federally qualified health care centers, and home
3125 health care agencies.

3126 (4) "Qualified plan" means a managed care plan that is
3127 determined eligible to participate in the Medicaid managed care
3128 program pursuant to s. 409.965.

3129 (5) "Specialty plan" means a qualified plan that serves
3130 Medicaid recipients who meet specified criteria based on age,
3131 medical condition, or diagnosis.

3132 Section 37. Section 409.963, Florida Statutes, is created

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3133 to read:

3134 409.963 Medicaid managed care program.—The Medicaid managed
3135 care program is established as a statewide, integrated managed
3136 care program for all covered medical assistance services and
3137 long-term care services as provided under this part. Pursuant to
3138 s. 409.902, the program shall be administered by the agency, and
3139 eligibility for the program shall be determined by the
3140 Department of Children and Family Services.

3141 (1) The agency shall submit amendments to the Medicaid
3142 state plan or to existing waivers, or submit new waiver requests
3143 under section 1115 or other applicable sections of the Social
3144 Security Act, by August 1, 2011, as needed to implement the
3145 managed care program. At a minimum, the waiver requests must
3146 include a waiver that allows home and community-based services
3147 to be preferred over nursing home services for persons who can
3148 be safely managed in the home and community, and a waiver that
3149 requires dually eligible recipients to participate in the
3150 Medicaid managed care program. The waiver requests must also
3151 include provisions authorizing the state to limit enrollment in
3152 managed long-term care, establish waiting lists, and limit the
3153 amount, duration, and scope of home and community-based services
3154 to ensure that expenditures for persons eligible for managed
3155 long-term care services do not exceed funds provided in the
3156 General Appropriations Act.

3157 (a) The agency shall initiate any necessary procurements
3158 required to implement the managed care program as soon as
3159 practicable, but no later than July 1, 2011, in anticipation of
3160 prompt approval of the waivers needed for the managed care
3161 program by the United States Department of Health and Human

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3162 Services.

3163 (b) In submitting waivers, the agency shall work with the
3164 federal Centers for Medicare and Medicaid Services to accomplish
3165 approval of all waivers by December 1, 2011, in order to begin
3166 implementation of the managed care program by December 31, 2011.

3167 (c) Before seeking a waiver, the agency shall provide
3168 public notice and the opportunity for public comment and include
3169 public feedback in the waiver application.

3170 (2) The agency shall begin implementation of the Medicaid
3171 managed care program on December 31, 2011. If waiver approval is
3172 obtained, the program shall be implemented in accordance with
3173 the terms and conditions of the waiver. If necessary waivers
3174 have not been timely received, the agency shall notify the
3175 Centers for Medicare and Medicaid Services of the state's
3176 implementation of the managed care program and request the
3177 federal agency to continue providing federal funds equivalent to
3178 the funding level provided under the Federal Medical Assistance
3179 Percentage in order to implement the managed care program.

3180 (a) If the Centers for Medicare and Medicaid Services
3181 refuses to continue providing federal funds, the managed care
3182 program shall be implemented as a state-only funded program to
3183 the extent state funds are available.

3184 (b) If implemented as a state-only funded program, priority
3185 shall be given to providing:

3186 1. Nursing home services to persons eligible for nursing
3187 home care.

3188 2. Medical services to persons served by the Agency for
3189 Persons with Disabilities.

3190 3. Medical services to pregnant women.

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3191 4. Physician and hospital services to persons who are
3192 determined to be eligible for Medicaid subject to the income,
3193 assets, and categorical eligibility tests set forth in federal
3194 and state law.

3195 5. Services provided under the Healthy Start waiver.

3196 6. Medical services provided to persons in the Nursing Home
3197 Diversion waiver.

3198 7. Medical services provided to persons in intermediate
3199 care facilities for the developmentally disabled.

3200 8. Services to children in the child welfare system whose
3201 medical care is provided in accordance with s. 409.16713, as
3202 authorized by the General Appropriations Act.

3203 (c) If implemented as a state-only funded program pursuant
3204 to paragraph (b), provisions related to the eligibility
3205 standards of the state and federally funded Medicaid program
3206 remain in effect, except as otherwise provided under the managed
3207 care program.

3208 (d) If implemented as a state-only funded program pursuant
3209 to paragraph (a), provider agreements and other contracts that
3210 provide for Medicaid services to recipients identified in
3211 paragraph (b) continue in effect.

3212 Section 38. Section 409.964, Florida Statutes, is created
3213 to read:

3214 409.964 Enrollment.—All Medicaid recipients shall receive
3215 medical services through the Medicaid managed care program
3216 established under this part unless excluded under this section.

3217 (1) The following recipients are excluded from
3218 participation in the Medicaid managed care program:

3219 (a) Women who are eligible only for family planning

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3220 services.

3221 (b) Women who are eligible only for breast and cervical
3222 cancer services.

3223 (c) Persons who have a developmental disability as defined
3224 in s. 393.063.

3225 (d) Persons who are eligible for a Medicaid nonpoverty
3226 medical subsidy.

3227 (e) Persons who receive eligible services under emergency
3228 Medicaid for aliens.

3229 (f) Persons who are residing in a nursing home facility or
3230 are considered residents under the nursing home's bed-hold
3231 policy on or before July 1, 2011.

3232 (g) Persons who are eligible for and receiving prescribed
3233 pediatric extended care.

3234 (h) A person who is eligible for services under the
3235 Medicaid program who has access to health care coverage through
3236 an employer-sponsored health plan. Such person may not receive
3237 Medicaid services under the fee-for-service program but may use
3238 Medicaid financial assistance to pay the cost of premiums for
3239 the employer-sponsored health plan. For purposes of this
3240 paragraph, access to health care coverage through an employer-
3241 sponsored health plan means that the Medicaid financial
3242 assistance available to the person is sufficient to pay the
3243 premium for the employer-sponsored health plan for the eligible
3244 person and his or her Medicaid eligible family members.

3245 1. The agency shall develop a process that allows a
3246 recipient who has access to employer-sponsored health coverage
3247 to use Medicaid financial assistance to pay the cost of the
3248 premium for the recipient and the recipient's Medicaid-eligible

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3249 family members for such coverage. The amount of financial
3250 assistance may not exceed the Medicaid capitated rate that would
3251 have been paid to a qualified plan for that recipient and the
3252 recipient's family members.

3253 2. Contingent upon federal approval, the agency shall also
3254 allow recipients who have access to other insurance or coverage
3255 created pursuant to state or federal law to opt out of Medicaid
3256 managed care and apply the Medicaid capitated rate that would
3257 have been paid to a qualified plan for that recipient and the
3258 recipient's family to pay for the other insurance product.

3259 (2) The following Medicaid recipients are exempt from
3260 mandatory enrollment in the managed care program but may
3261 volunteer to participate in the program:

3262 (a) Recipients residing in residential commitment
3263 facilities operated through the Department of Juvenile Justice,
3264 group care facilities operated by the Department of Children and
3265 Family Services, or treatment facilities funded through the
3266 substance abuse and mental health program of the Department of
3267 Children and Family Services.

3268 (b) Persons eligible for refugee assistance.

3269 (3) Medicaid recipients who are exempt from mandatory
3270 participation under this section and who do not choose to enroll
3271 in the Medicaid managed care program shall be served through the
3272 Medicaid fee-for-service program as provided under part III of
3273 this chapter.

3274 Section 39. Section 409.965, Florida Statutes, is created
3275 to read:

3276 409.965 Qualified plans; regions; selection criteria.—
3277 Services in the Medicaid managed care program shall be provided

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3278 by qualified plans.

3279 (1) The agency shall select qualified plans to participate
3280 in the Medicaid managed care program using an invitation to
3281 negotiate issued pursuant to s. 287.057.

3282 (a) The agency shall notice separate invitations to
3283 negotiate for the managed medical assistance component and the
3284 managed long-term care component of the managed care program.

3285 (b) At least 30 days before noticing the invitation to
3286 negotiate and annually thereafter, the agency shall compile and
3287 publish a databook consisting of a comprehensive set of
3288 utilization and spending data for the 3 most recent contract
3289 years, consistent with the rate-setting periods for all Medicaid
3290 recipients by region and county. Pursuant to s. 409.970, the
3291 source of the data must include both historic fee-for-service
3292 claims and validated data from the Medicaid Encounter Data
3293 System. The report shall be made available electronically and
3294 must delineate utilization by age, gender, eligibility group,
3295 geographic area, and acuity level.

3296 (2) Separate and simultaneous procurements shall be
3297 conducted in each of the following regions:

3298 (a) Region 1, which consists of Escambia, Okaloosa, Santa
3299 Rosa, and Walton counties.

3300 (b) Region 2, which consists of Franklin, Gadsden,
3301 Jefferson, Leon, Liberty, and Wakulla counties.

3302 (c) Region 3, which consists of Columbia, Dixie, Hamilton,
3303 Lafayette, Madison, Suwannee, and Taylor counties.

3304 (d) Region 4, which consists of Baker, Clay, Duval, and
3305 Nassau counties.

3306 (e) Region 5, which consists of Citrus, Hernando, Lake,

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- 3307 Marion, and Sumter counties.
- 3308 (f) Region 6, which consists of Pasco and Pinellas
- 3309 counties.
- 3310 (g) Region 7, which consists of Flagler, Putnam, St. Johns,
- 3311 and Volusia counties.
- 3312 (h) Region 8, which consists of Alachua, Bradford,
- 3313 Gilchrist, Levy, and Union counties.
- 3314 (i) Region 9, which consists of Orange and Osceola
- 3315 counties.
- 3316 (j) Region 10, which consists of Hardee, Highlands, and
- 3317 Polk counties.
- 3318 (k) Region 11, which consists of Miami-Dade and Monroe
- 3319 counties.
- 3320 (l) Region 12, which consists of DeSoto, Manatee, and
- 3321 Sarasota counties.
- 3322 (m) Region 13, which consists of Hillsborough County.
- 3323 (n) Region 14, which consists of Bay, Calhoun, Gulf,
- 3324 Holmes, Jackson, and Washington counties.
- 3325 (o) Region 15, which consists of Palm Beach County.
- 3326 (p) Region 16, which consists of Broward County.
- 3327 (q) Region 17, which consists of Brevard and Seminole
- 3328 counties.
- 3329 (r) Region 18, which consists of Indian River, Martin,
- 3330 Okeechobee, and St. Lucie counties.
- 3331 (s) Region 19, which consists of Charlotte, Collier,
- 3332 Glades, Hendry, and Lee counties.
- 3333 (3) The invitation to negotiate must specify the criteria
- 3334 and the relative weight of the criteria to be used for
- 3335 determining the acceptability of a reply and guiding the

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3336 selection of qualified plans with which the agency shall
3337 contract. In addition to other criteria developed by the agency,
3338 the agency shall give preference to the following factors in
3339 selecting qualified plans:

3340 (a) Accreditation by the National Committee for Quality
3341 Assurance or another nationally recognized accrediting body.

3342 (b) Experience serving similar populations, including the
3343 organization's record in achieving specific quality standards
3344 for similar populations.

3345 (c) Availability and accessibility of primary care and
3346 specialty physicians in the provider network.

3347 (d) Establishment of partnerships with community providers
3348 that provide community-based services.

3349 (e) The organization's commitment to quality improvement
3350 and documentation of achievements in specific quality-
3351 improvement projects, including active involvement by the
3352 organization's leadership.

3353 (f) Provision of additional benefits, particularly dental
3354 care for all recipients, disease management, and other programs
3355 offering additional benefits.

3356 (g) Establishment of incentive programs that reward
3357 specific behaviors with health-related benefits not otherwise
3358 covered by the organizations' benefit plan. Such behaviors may
3359 include participation in smoking-cessation programs, weight-loss
3360 programs, or other activities designed to mitigate lifestyle
3361 choices and avoid behaviors associated with the use of high-cost
3362 medical services.

3363 (h) Organizations without a history of voluntary or
3364 involuntary withdrawal from any state Medicaid program or

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3365 program area.

3366 (i) Evidence that an organization has written agreements or
3367 signed contracts or has made substantial progress in
3368 establishing relationships with providers before the
3369 organization submits a reply. The agency shall evaluate such
3370 evidence based on the following factors:

3371 1. Contracts with primary care and specialty physicians in
3372 sufficient numbers to meet the specific standards established in
3373 s. 409.966(2) (b) .

3374 2. Specific arrangements that provide evidence that the
3375 compensation offered by the plan is sufficient to retain primary
3376 care and specialty physicians in sufficient numbers to comply
3377 with the standards established in s. 409.966(2) throughout the
3378 5-year contract term. The agency shall give preference to plans
3379 that provide evidence that primary care physicians within the
3380 plan's provider network will be compensated for primary care
3381 services with payments equivalent to or greater than payments
3382 for such services under the Medicare program, whether
3383 compensation is made on a fee-for-service basis or by sub-
3384 capitation.

3385 3. Contracts with community pharmacies located in rural
3386 areas; contracts with community pharmacies serving specialty
3387 disease populations, including, but not limited to, HIV/AIDS
3388 patients, hemophiliacs, patients suffering from end-stage renal
3389 disease, diabetes, or cancer; community pharmacies located
3390 within distinct cultural communities that reflect the unique
3391 cultural dynamics of such communities, including, but not
3392 limited to, languages spoken, ethnicities served, unique disease
3393 states serviced, and geographic location within the neighborhood

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3394 of a culturally distinct populations; and community pharmacies
3395 providing value-added services to patients, such as free
3396 delivery, immunizations, disease management, diabetes education,
3397 and medication utilization review.

3398 (j) The capitated rates provided in the reply to the
3399 invitation to negotiate.

3400 (k) Establishment of a claims payment process to ensure
3401 that claims that are not contested or denied will be paid within
3402 20 days after receipt.

3403 (l) For long-term care plans, additional criteria as
3404 specified in s. 409.976(3).

3405 (4) Acceptable replies to the invitation to negotiate for
3406 each region shall be ranked, and the agency shall select the
3407 number of qualified plans with which to contract in each region.

3408 (a) The agency may not select more than one plan per 20,000
3409 Medicaid recipients residing in the region who are subject to
3410 mandatory managed care enrollment, except that, in addition to
3411 the Children's Medical Services Network, a region may not have
3412 more than 10 qualified plans for the managed medical assistance
3413 or the managed long-term care components of the program.

3414 (b) If the funding available in the General Appropriations
3415 Act is not adequate to meet the proposed statewide requirement
3416 under the Medicaid managed care program, the agency shall enter
3417 into negotiations with qualified plans that responded to the
3418 invitation to negotiate. The negotiation process may alter the
3419 rank of a qualified plan. If negotiations are conducted, the
3420 agency shall select qualified plans that are responsive and
3421 provide the best value to the state.

3422 (5) The Children's Medical Services Network authorized

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3423 under chapter 391 is a qualified plan for purposes of the
3424 managed care medical assistance component of the Medicaid
3425 managed care program. Participation by the network shall be
3426 pursuant to a single statewide contract with the agency which is
3427 not subject to the procurement requirements of this section. The
3428 network must meet all other plan requirements for the managed
3429 care medical assistance component of the program.

3430 Section 40. Section 409.966, Florida Statutes, is created
3431 to read:

3432 409.966 Plan contracts.—

3433 (1) The agency shall execute a 5-year contract with each
3434 qualified plan selected through the procurement process
3435 described in s. 409.965. A contract between the agency and the
3436 qualified plan may be amended annually, or as needed, to reflect
3437 capitated rate adjustments due to funding availability pursuant
3438 to the General Appropriations Act and ss. 409.9022, 409.972, and
3439 409.975(2).

3440 (a) A plan contract may not be renewed; however, the agency
3441 may extend the term of a contract, keeping intact all
3442 operational provisions in the contract, including capitation
3443 rates, to cover any delays in transitioning to a new plan.

3444 (b) If a plan applies for a rate increase that is not the
3445 result of a solicitation from the agency and the application for
3446 rate increase is not timely withdrawn, the plan will be deemed
3447 to have submitted a notice of intent to leave the region before
3448 the end of the contract term.

3449 (2) The agency shall establish such contract requirements
3450 as are necessary for the operation of the Medicaid managed care
3451 program. In addition to any other provisions the agency may deem

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3452 necessary, the contract must require:

3453 (a) Access.—The agency shall establish specific standards
3454 for the number, type, and regional distribution of providers in
3455 plan networks in order to ensure access to care. Each qualified
3456 plan shall:

3457 1. Maintain a network of providers in sufficient numbers to
3458 meet the access standards for specified services for all
3459 recipients enrolled in the plan.

3460 2. Establish and maintain an accurate and complete
3461 electronic database of contracted providers, including
3462 information about licensure or registration, locations and hours
3463 of operation, specialty credentials and other certifications,
3464 specific performance indicators, and such other information as
3465 the agency deems necessary. The provider database must be
3466 available online to both the agency and the public and allow
3467 comparison of the availability of providers to network adequacy
3468 standards, and accept and display feedback from each provider's
3469 patients.

3470 3. Provide for reasonable and adequate hours of operation,
3471 including 24-hour availability of information, referral, and
3472 treatment for emergency medical conditions.

3473 4. Assign each new enrollee to a primary care provider and
3474 ensure that an appointment with that provider has been scheduled
3475 within 30 days after the enrollment in the plan.

3476 5. Submit quarterly reports to the agency identifying the
3477 number of enrollees assigned to each primary care provider.

3478 (b) Performance standards.—The agency shall establish
3479 specific performance standards and expected milestones or
3480 timelines for improving plan performance over the term of the

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3481 contract.

3482 1. Each plan shall establish an internal health care
3483 quality improvement system that includes enrollee satisfaction
3484 and disenrollment surveys and incentives and disincentives for
3485 network providers.

3486 2. A qualified plan that is not accredited when the
3487 contract is executed with the agency must become accredited or
3488 have initiated the accreditation process within 1 year after the
3489 contract is executed. If the plan is not accredited within 18
3490 months after executing the contract, the plan shall be suspended
3491 from automated enrollments pursuant to s. 409.969(2).

3492 3. In addition to agency standards, a qualified plan must
3493 ensure that the agency is notified of the impending birth of a
3494 child to an enrollee or as soon as practicable after the child's
3495 birth. Upon the birth, the child is deemed enrolled with the
3496 qualified plan, regardless of the administrative enrollment
3497 procedures, and the qualified plan is responsible for providing
3498 Medicaid services to the child on a capitated basis.

3499 (c) Program integrity.—Each plan shall establish program
3500 integrity functions and activities in order to reduce the
3501 incidence of fraud and abuse, including, at a minimum:

3502 1. A provider credentialing system and ongoing provider
3503 monitoring. Each plan must verify at least annually that all
3504 providers have a valid and unencumbered license or permit to
3505 provide services to Medicaid recipients, and shall establish a
3506 procedure for providers to notify the plan when the provider has
3507 been notified by a licensing or regulatory agency that the
3508 provider's license or permit is to be revoked or suspended, or
3509 when an event has occurred which would prevent the provider from

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3510 renewing its license or permit. The provider must also notify
3511 the plan if the license or permit is revoked or suspended, if
3512 renewal of the license or permit is denied or expires by
3513 operation of law, or if the provider requests that the license
3514 or permit be inactivated. The plan must immediately exclude a
3515 provider from the plan's provider network if the provider's
3516 license is suspended or invalid;

3517 2. An effective prepayment and postpayment review process
3518 that includes, at a minimum, data analysis, system editing, and
3519 auditing of network providers;

3520 3. Procedures for reporting instances of fraud and abuse
3521 pursuant to s. 409.91212;

3522 4. The establishment of an anti-fraud plan pursuant to s.
3523 409.91212; and

3524 5. Designation of a program integrity compliance officer.

3525 (d) Encounter data.—Each plan must comply with the agency's
3526 reporting requirements for the Medicaid Encounter Data System
3527 under s. 409.970. The agency shall assess a fine of \$5,000 per
3528 day against a qualified plan for failing to comply with this
3529 requirement. If a plan fails to comply for more than 30 days,
3530 the agency shall assess a fine of \$10,000 per day beginning on
3531 the 31st day. If a plan is fined \$300,000 or more for failing to
3532 comply, in addition to paying the fine, the plan shall be
3533 disqualified from the Medicaid managed care program for 3 years.
3534 If the plan is disqualified, the plan shall be deemed to have
3535 terminated its contract before the scheduled end date and shall
3536 also be subject to applicable penalties under paragraph (1).
3537 However, the agency may waive or reduce the fine upon a showing
3538 of good cause for the failure to comply.

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3539 (e) *Electronic claims.*—Plans shall accept electronic claims
3540 that are in compliance with federal standards.

3541 (f) *Prompt payment.*—All qualified plans must comply with
3542 ss. 641.315, 641.3155, and 641.513. Qualified plans shall pay
3543 nursing homes by the 10th day of the month for enrollees who are
3544 residing in the nursing home on the 1st day of the month.
3545 Payment for the month in which an enrollee initiates residency
3546 in a nursing home shall be in accordance with s. 641.3155. On an
3547 annual basis, qualified plans shall submit a report certifying
3548 compliance with the prompt payment requirements for the plan
3549 year.

3550 (g) *Emergency services.*—Qualified plans must pay for
3551 emergency services and care required under ss. 395.1041 and
3552 401.45 and rendered by a noncontracted provider in accordance
3553 with the prompt payment standards established in s. 641.3155.
3554 The payment rate shall be the fee-for-service rate the agency
3555 would pay the noncontracted provider for such services.

3556 (h) *Surety bond.*—A qualified plan shall post and maintain a
3557 surety bond with the agency, payable to the agency, in the
3558 amount of \$1.5 million. In lieu of a surety bond, the qualified
3559 plan may establish and maintain an irrevocable letter of credit
3560 or a deposit in a trust account in a financial institution,
3561 payable to the agency, for \$1.5 million. The purpose of the
3562 surety bond, letter of credit, or trust account is to protect
3563 the agency if the entity terminates its contract with the agency
3564 before the scheduled end date for the contract, the plan fails
3565 to comply with the terms of the contract, including, but not
3566 limited to, the timely submission of encounter data, the agency
3567 imposes fines or penalties for noncompliance, or the plan fails

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3568 to achieve the guaranteed savings. If the contract is terminated
3569 by the plan for any reason, the agency imposes fines or
3570 penalties for noncompliance, or the guaranteed savings are not
3571 achieved, the agency shall first request payment from the
3572 qualified plan. If the qualified plan has not paid all costs,
3573 fines, penalties, or the differential in the guaranteed savings
3574 in full within 30 days, the agency shall pursue a claim against
3575 the surety bond, letter of credit, or trust account for all
3576 applicable moneys and the legal and administrative costs
3577 associated with claiming under the surety bond, letter of
3578 credit, or trust account.

3579 (i) Grievance resolution.—Each plan shall establish and the
3580 agency shall approve an internal process for reviewing and
3581 responding to grievances from enrollees consistent with s.
3582 641.511. Each plan shall submit quarterly reports to the agency
3583 on the number, description, and outcome of grievances filed by
3584 enrollees.

3585 (j) Solvency.—A qualified plan must meet and maintain the
3586 surplus and solvency requirements under s. 409.912(17) and (18).
3587 A provider service network may satisfy the surplus and solvency
3588 requirements if the network's performance and financial
3589 obligations are guaranteed in writing by an entity licensed by
3590 the Office of Insurance Regulation which meets the surplus and
3591 solvency requirements of s. 624.408 or s. 641.225.

3592 (k) Guaranteed savings.—During the first contract period, a
3593 qualified plan must agree to provide a guaranteed minimum
3594 savings of 7 percent to the state. The agency shall conduct a
3595 cost reconciliation to determine the amount of cost savings
3596 achieved by the qualified plan compared with the reimbursements

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3597 the agency would have incurred under fee-for-service provisions.

3598 (1) Costs and penalties.—Plans that reduce enrollment
3599 levels or leave a region before the end of the contract term
3600 must reimburse the agency for the cost of enrollment changes and
3601 other transition activities. If more than one plan leaves a
3602 region at the same time, costs shall be shared by the departing
3603 plans proportionate to their enrollment. In addition to the
3604 payment of costs, departing plans must pay a penalty of 1
3605 month's payment calculated as an average of the past 12 months
3606 of payments, or since inception if the plan has not contracted
3607 with the agency for 12 months, plus the differential of the
3608 guaranteed savings based on the original contract term and the
3609 corresponding termination date. Plans must provide the agency
3610 with at least 180 days' notice before withdrawing from a region.

3611 (3) If the agency terminates more than one regional
3612 contract with a qualified plan due to the plan's noncompliance
3613 with one or more requirements of this section, the agency shall
3614 terminate all regional contracts with the plan under the
3615 Medicaid managed care program, as well as any other contracts or
3616 agreements for other programs or services, and the plan may not
3617 be awarded new contracts for 3 years.

3618 Section 41. Section 409.967, Florida Statutes, is created
3619 to read:

3620 409.967 Plan accountability.—In addition to the contract
3621 requirements of s. 409.966, plans and providers participating in
3622 the Medicaid managed care program must comply with this section.

3623 (1) The agency shall require qualified plans to use a
3624 uniform method of reporting and accounting for medical, direct
3625 care management, and nonmedical costs. The agency shall evaluate

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3626 plan spending patterns after the plan completes 2 full years of
3627 operation and at least annually thereafter. The agency shall
3628 implement the following thresholds and consequences of various
3629 spending patterns for qualified plans under the managed medical
3630 assistance component of the Medicaid managed care program:

3631 (a) The minimum medical loss ratio shall be 90 percent.

3632 (b) A plan that spends less than 90 percent of its Medicaid
3633 capitation revenue on medical services and direct care
3634 management, as determined by the agency, must pay back to the
3635 agency a share of the dollar difference between the plan's
3636 actual medical loss ratio and the minimum medical loss ratio, as
3637 follows:

3638 1. If the plan's actual medical loss ratio is not lower
3639 than 87 percent, the plan must pay back 50 percent of the dollar
3640 difference between the actual medical loss ratio and the minimum
3641 medical loss ratio of 90 percent.

3642 2. If the plan's actual medical loss ratio is lower than 87
3643 percent, the plan must pay back 50 percent of the dollar
3644 difference between a medical loss ratio of 87 percent and the
3645 minimum medical loss ratio of 90 percent, plus 100 percent of
3646 the dollar difference between the actual medical loss ratio and
3647 a medical loss ratio of 87 percent.

3648 (c) To administer this subsection, the agency shall adopt
3649 rules that specify a methodology for calculating medical loss
3650 ratios and the requirements for plans to annually report
3651 information related to medical loss ratios. Repayments required
3652 by this subsection must be made annually.

3653 (2) Plans may limit the providers in their networks.

3654 (a) However, during the first year in which a qualified

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3655 plan is operating in a region after the initial plan procurement
3656 for that region, the plan must offer a network contract to the
3657 following providers in the region:

3658 1. Federally qualified health centers.

3659 2. Nursing homes if the plan is providing managed long-term
3660 care services.

3661 3. Aging network service providers that have previously
3662 participated in home and community-based waivers serving elders,
3663 or community-service programs administered by the Department of
3664 Elderly Affairs if the plan is providing managed long-term care
3665 services.

3666 (b) After 12 months of active participation in a plan's
3667 network, the plan may exclude any of the providers listed in
3668 paragraph (a) from the network while maintaining network
3669 adequacy standards required under s. 409.966(2) (b). If the plan
3670 excludes a nursing home that meets the standards for ongoing
3671 Medicaid certification, the plan must provide an alternative
3672 residence in that community for Medicaid recipients residing in
3673 that nursing home. If a Medicaid recipient residing in an
3674 excluded nursing home does not choose to change residence, the
3675 plan must continue to pay for the recipient's care in that
3676 nursing home. If the plan excludes a provider, the plan must
3677 provide written notice to all enrollees who have chosen that
3678 provider for care. Notice to excluded providers must be
3679 delivered at least 30 days before the effective date of the
3680 exclusion.

3681 (c) Qualified plans and providers shall engage in good
3682 faith negotiations to reach contract terms.

3683 1. If a qualified plan seeks to develop a provider network

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3684 in a county or region that, as of June 30, 2011, does not have a
3685 capitated managed care plan providing comprehensive acute care
3686 for Medicaid recipients, and the qualified plan has made at
3687 least three documented, unsuccessful, good faith attempts to
3688 contract with a specific provider, the plan may request the
3689 agency to examine the negotiation process. During the
3690 examination, the agency shall consider similar counties or
3691 regions in which qualified plans have contracted with providers
3692 under similar circumstances, as well as the contracted rates
3693 between qualified plans and that provider and similar providers
3694 in the same region. If the agency determines that the plan has
3695 made three good faith attempts to contract with the provider,
3696 the agency shall consider that provider to be part of the
3697 qualified plan's provider network for the purpose of determining
3698 network adequacy, and the plan shall pay the provider for
3699 services to Medicaid recipients on a noncontracted basis at a
3700 rate or rates determined by the agency to be the average of
3701 rates for corresponding services paid by the qualified plan and
3702 other qualified plans in the region and in similar counties or
3703 regions under similar circumstances.

3704 2. The agency may continue to calculate Medicaid hospital
3705 inpatient per diem rates and outpatient rates. However, these
3706 rates may not be the basis for contract negotiations between a
3707 managed care plan and a hospital.

3708 (3) Each qualified plan shall monitor the quality and
3709 performance of each provider within its network based on metrics
3710 established by the agency for evaluating and documenting
3711 provider performance and determining continued participation in
3712 the network. The agency shall establish requirements for

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3713 qualified plans to report, at least annually, provider
3714 performance data compiled under this subsection. If a plan uses
3715 additional metrics to evaluate the provider's performance and to
3716 determine continued participation in the network, the plan must
3717 notify the network providers of these metrics at the beginning
3718 of the contract period.

3719 (a) At a minimum, a qualified plan shall hold primary care
3720 physicians responsible for the following activities:

3721 1. Supervision, coordination, and provision of care to each
3722 assigned enrollee.

3723 2. Initiation of referrals for medically necessary
3724 specialty care and other services.

3725 3. Maintaining continuity of care for each assigned
3726 enrollee.

3727 4. Maintaining the enrollee's medical record, including
3728 documentation of all medical services provided to the enrollee
3729 by the primary care physician, as well as any specialty or
3730 referral services.

3731 (b) Qualified plans shall establish and implement policies
3732 and procedures to monitor primary care physician activities and
3733 ensure that primary care physicians are adequately notified and
3734 receive documentation of specialty and referral services
3735 provided to enrollees by specialty physicians and other health
3736 care providers within the plan's provider network.

3737 (4) Each qualified plan shall establish specific programs
3738 and procedures to improve pregnancy outcomes and infant health,
3739 including, but not limited to, coordination with the Healthy
3740 Start program, immunization programs, and referral to the
3741 Special Supplemental Nutrition Program for Women, Infants, and

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3742 Children, and the Children's Medical Services Program for
3743 children with special health care needs.

3744 (a) Qualified plans must ensure that primary care
3745 physicians who provide obstetrical care are available to
3746 pregnant recipients and that an obstetrical care provider is
3747 assigned to each pregnant recipient for the duration of her
3748 pregnancy and postpartum care, by referral of the recipient's
3749 primary care physician if necessary.

3750 (b) Qualified plans within the managed long-term care
3751 component are exempt from this subsection.

3752 (5) Each qualified plan shall achieve an annual screening
3753 rate for early and periodic screening, diagnosis, and treatment
3754 services of at least 80 percent of those recipients continuously
3755 enrolled for at least 8 months. Qualified plans within the
3756 managed long-term care component are exempt from this
3757 requirement.

3758 (6) Effective January 1, 2013, qualified plans must
3759 compensate primary care physicians for primary care services at
3760 payment rates that are equivalent to or greater than payments
3761 under the federal Medicare program, whether compensation is made
3762 on a fee-for-service basis or by sub-capitation.

3763 (7) In order to protect the continued operation of the
3764 Medicaid managed care program, unresolved disputes, including
3765 claim and other types of disputes, between a qualified plan and
3766 a provider shall proceed in accordance with s. 408.7057. This
3767 process may not be used to review or reverse a decision by a
3768 qualified plan to exclude a provider from its network if the
3769 decision does not conflict with s. 409.967(2).

3770 Section 42. Section 409.968, Florida Statutes, is created

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3771 to read:

3772 409.968 Plan payment.—Payments for managed medical
3773 assistance and managed long-term care services under this part
3774 shall be made in accordance with a capitated managed care model.
3775 Qualified plans shall receive per-member, per-month payments
3776 pursuant to the procurements described in s. 409.965 and annual
3777 adjustments as described in s. 409.966(1). Payment rates must be
3778 based on the acuity level for each member pursuant to ss.
3779 409.972 and 409.978. Payment rates for managed long-term care
3780 plans shall be combined with rates for managed medical
3781 assistance plans.

3782 (1) The agency shall develop a methodology and request a
3783 waiver that ensures the availability of intergovernmental
3784 transfers in the Medicaid managed care program to support
3785 providers that have historically served Medicaid recipients.
3786 Such providers include, but are not limited to, safety net
3787 providers, trauma hospitals, children's hospitals, statutory
3788 teaching hospitals, and medical and osteopathic physicians
3789 employed by or under contract with a medical school in this
3790 state. The agency may develop a supplemental capitation rate,
3791 risk pool, or incentive payment for plans that contract with
3792 these providers. A plan is eligible for a supplemental payment
3793 only if there are sufficient intergovernmental transfers
3794 available from allowable sources.

3795 (2) The agency shall evaluate the development of the rate
3796 cell to accurately reflect the underlying utilization to the
3797 maximum extent possible. This methodology may include interim
3798 rate adjustments as permitted under federal regulations. Any
3799 such methodology must preserve federal funding to these entities

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3800 and be actuarially sound. In the absence of federal approval of
3801 the methodology, the agency may set an enhanced rate and require
3802 that plans pay the rate if the agency determines the enhanced
3803 rate is necessary to ensure access to care by the providers
3804 described in this subsection.

3805 (3) The amount paid to the plans to make supplemental
3806 payments or to enhance provider rates pursuant to this
3807 subsection must be reconciled to the exact amounts the plans are
3808 required to pay providers. The plans shall make the designated
3809 payments to providers within 15 business days after notification
3810 by the agency regarding provider-specific distributions.

3811 Section 43. Section 409.969, Florida Statutes, is created
3812 to read:

3813 409.969 Enrollment; disenrollment; grievance procedure.—

3814 (1) Each Medicaid recipient may choose any available plan
3815 within the region in which the recipient resides unless that
3816 plan is a specialty plan for which the recipient does not
3817 qualify. The agency may not provide or contract for choice
3818 counseling services for persons enrolling in the Medicaid
3819 managed care program.

3820 (2) If a recipient has not made a choice of plans within 30
3821 days after having been notified to choose a plan, the agency
3822 shall assign the recipient to a plan in accordance with the
3823 following:

3824 (a) A recipient who was previously enrolled in a plan
3825 within the preceding 90 days shall be automatically enrolled in
3826 the same plan, if available. Newborns of eligible mothers
3827 enrolled in a plan at the time of the child's birth shall be
3828 enrolled in the mother's plan; however, the mother may choose

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3829 another plan for the newborn within 90 days after the child's
3830 birth. Other recipients shall be enrolled into a qualified plan
3831 in accordance with an auto-assignment enrollment algorithm that
3832 the agency develops by rule. The algorithm must heavily weigh
3833 family continuity.

3834 (b) The agency shall automatically enroll recipients in
3835 plans that meet or exceed the performance or quality standards
3836 established pursuant to s. 409.967, and may not automatically
3837 enroll recipients in a plan that is not meeting those standards.
3838 Except as provided by law or rule, the agency may not engage in
3839 practices that favor one qualified plan over another.

3840 (c) Automatic enrollment of recipients in plans must be
3841 based on the following criteria:

3842 1. Whether the plan has sufficient network capacity to meet
3843 the needs of recipients.

3844 2. Whether the recipient has previously received services
3845 from one of the plan's primary care providers.

3846 3. Whether primary care providers in one plan are more
3847 geographically accessible to the recipient's residence than
3848 those providers in other plans.

3849 4. If a recipient is eligible for long-term care services,
3850 whether the recipient has previously received services from one
3851 of the plan's home and community-based service providers.

3852 5. If a recipient is eligible for long-term care services,
3853 whether the home and community-based providers in one plan are
3854 more geographically accessible to the recipient's residence than
3855 those providers in other plans.

3856 (3) After a recipient has enrolled in a qualified plan, the
3857 enrollee shall have 90 days to voluntarily disenroll and select

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3858 another plan. After 90 days, no further changes may be made
3859 except for good cause. Good cause includes, but is not limited
3860 to, poor quality of care, lack of access to necessary specialty
3861 services, an unreasonable delay or denial of service, or
3862 fraudulent enrollment. The agency shall determine whether good
3863 cause exists. The agency may require an enrollee to use the
3864 plan's grievance process before the agency makes a determination
3865 of good cause, unless an immediate risk of permanent damage to
3866 the enrollee's health is alleged.

3867 (a) If used, the qualified plan's internal grievance
3868 process must be completed in time to allow the enrollee to
3869 disenroll by the first day of the second month after the month
3870 the disenrollment request was made. If the grievance process
3871 approves an enrollee's request to disenroll, the agency is not
3872 required to make a determination of good cause.

3873 (b) The agency must make a determination of good cause and
3874 take final action on an enrollee's request so that disenrollment
3875 occurs by the first day of the second month after the month the
3876 request was made. If the agency fails to act within this
3877 timeframe, the enrollee's request to disenroll is deemed
3878 approved as of the date agency action was required. Enrollees
3879 who disagree with the agency's finding that good cause for
3880 disenrollment does not exist shall be advised of their right to
3881 pursue a Medicaid fair hearing to dispute the agency's finding.

3882 (c) Medicaid recipients enrolled in a qualified plan after
3883 the 90-day period must remain in the plan for the remainder of
3884 the 12-month period. After 12 months, the enrollee may select
3885 another plan. However, if a recipient is referred for hospice
3886 services, the recipient shall have 30 days to enroll in another

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3887 plan in order to access the hospice provider of the recipient's
3888 choice. An enrollee may change primary care providers within the
3889 plan at any time.

3890 (d) On the first day of the next month after receiving
3891 notice from a recipient that the recipient has moved to another
3892 region, the agency shall automatically disenroll the recipient
3893 from the plan the recipient is currently enrolled in and treat
3894 the recipient as if the recipient is a new enrollee. At that
3895 time, the recipient may choose another plan pursuant to the
3896 enrollment process established in this section.

3897 Section 44. Section 409.970, Florida Statutes, is created
3898 to read:

3899 409.970 Medicaid Encounter Data System.—The agency shall
3900 maintain and operate the Medicaid Encounter Data System to
3901 collect, process, and report on covered services provided to all
3902 Medicaid recipients enrolled in qualified plans.

3903 (1) Qualified plans shall submit encounter data
3904 electronically in a format that complies with provisions of the
3905 federal Health Insurance Portability and Accountability Act for
3906 electronic claims and in accordance with deadlines established
3907 by the agency. Plans must certify that the data reported is
3908 accurate and complete. The agency is responsible for validating
3909 the data submitted by the plans.

3910 (2) The agency shall develop methods and protocols for
3911 ongoing analysis of the encounter data, which must adjust for
3912 differences in the characteristics of enrollees in order to
3913 allow for the comparison of service utilization among plans. The
3914 analysis shall be used to identify possible cases of systemic
3915 overutilization, underutilization, inappropriate denials of

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3916 claims, and inappropriate utilization of covered services, such
3917 as higher than expected emergency department and pharmacy
3918 encounters. One of the primary focus areas for the analysis
3919 shall be the use of prescription drugs.

3920 (3) The agency shall provide periodic feedback to the plans
3921 based on the analysis and establish corrective action plans if
3922 necessary.

3923 (4) The agency shall make encounter data available to plans
3924 accepting enrollees who are reassigned to them from other plans
3925 leaving a region.

3926 (5) Beginning July 1, 2011, the agency shall conduct
3927 appropriate tests and establish specific criteria for
3928 determining whether the Medicaid Encounter Data System has
3929 valid, complete, and sound data for a sufficient period of time
3930 to provide qualified plans with a reliable basis for determining
3931 and proposing actuarially sound payment rates.

3932 Section 45. Section 409.971, Florida Statutes, is created
3933 to read:

3934 409.971 Managed care medical assistance.—Pursuant to s.
3935 409.902, the agency shall administer the managed care medical
3936 assistance component of the Medicaid managed care program
3937 described in this section and s. 409.972. Unless otherwise
3938 specified, the provisions of ss. 409.961-409.970 apply to the
3939 provision of managed care medical assistance. By December 31,
3940 2011, the agency shall begin implementation of managed care
3941 medical assistance, and full implementation in all regions must
3942 be completed by December 31, 2012.

3943 Section 46. Section 409.972, Florida Statutes, is created
3944 to read:

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- 3945 409.972 Managed care medical assistance services.-
3946 (1) Qualified plans providing managed care medical
3947 assistance must, at a minimum, cover the following services:
3948 (a) Ambulatory patient services.
3949 (b) Dental services for a recipient who is under age 21.
3950 (c) Dental services as provided in s. 627.419(7) for a
3951 recipient who is 21 years of age or older.
3952 (d) Dialysis services.
3953 (e) Durable medical equipment and supplies.
3954 (f) Early periodic screening diagnosis and treatment
3955 services, hearing services and hearing aids, and vision services
3956 and eyeglasses for enrollees under age 21.
3957 (g) Emergency services.
3958 (h) Family planning services.
3959 (i) Hearing services for a recipient who is under age 21.
3960 (j) Hearing services that are medically indicated for a
3961 recipient who is 21 years of age or older.
3962 (k) Home health services.
3963 (l) Hospice services.
3964 (m) Hospital inpatient services.
3965 (n) Hospital outpatient services.
3966 (o) Laboratory and imaging services.
3967 (p) Maternity and newborn care and birth center services.
3968 (q) Mental health services, substance abuse disorder
3969 services, and behavioral health treatment.
3970 (r) Prescription drugs.
3971 (s) Primary care service, referred specialty care services,
3972 preventive services, and wellness services.
3973 (t) Skilled nursing facility or inpatient rehabilitation

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3974 facility services.
3975 (u) Transplant services.
3976 (v) Transportation to access covered services.
3977 (w) Vision services for a recipient who is under age 21.
3978 (x) Vision services that are medically indicated for a
3979 recipient who is 21 years of age or older.
3980 (2) Subject to specific appropriations, the agency may make
3981 payments for services that are optional.
3982 (3) Qualified plans may customize benefit packages for
3983 nonpregnant adults, vary cost-sharing provisions, and provide
3984 coverage for additional services. The agency shall evaluate the
3985 proposed benefit packages to ensure that services are sufficient
3986 to meet the needs of the plans' enrollees and to verify
3987 actuarial equivalence.
3988 (4) Managed care medical assistance services provided under
3989 this section must be medically necessary and provided in
3990 accordance with state and federal law. This section does not
3991 prevent the agency from adjusting fees, reimbursement rates,
3992 lengths of stay, number of visits, or number of services, or
3993 from making any other adjustments necessary to comply with the
3994 availability of funding and any limitations or directions
3995 provided in the General Appropriations Act, chapter 216, or s.
3996 409.9022.
3997 Section 47. Section 409.973, Florida Statutes, is created
3998 to read:
3999 409.973 Managed long-term care.—
4000 (1) Qualified plans providing managed care medical
4001 assistance may also participate in the managed long-term care
4002 component of the Medicaid managed care program. Unless otherwise

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4003 specified, the provisions of ss. 409.961-409.970 apply to the
4004 managed long-term care component of the managed care program.

4005 (2) Pursuant to s. 409.902, the agency shall administer the
4006 managed long-term care component described in this section and
4007 ss. 409.974-409.978, but may delegate specific duties and
4008 responsibilities to the Department of Elderly Affairs and other
4009 state agencies. By March 31, 2012, the agency shall begin
4010 implementation of the managed long-term care component, with
4011 full implementation in all regions by March 31, 2013.

4012 (3) The Department of Elderly Affairs shall assist the
4013 agency in developing specifications for use in the invitation to
4014 negotiate and the model contract, determining clinical
4015 eligibility for enrollment in managed long-term care plans,
4016 monitoring plan performance and measuring quality of service
4017 delivery, assisting clients and families in order to address
4018 complaints with the plans, facilitating working relationships
4019 between plans and providers serving elders and disabled adults,
4020 and performing other functions specified in a memorandum of
4021 agreement.

4022 Section 48. Section 409.974, Florida Statutes, is created
4023 to read:

4024 409.974 Recipient eligibility for managed long-term care.-

4025 (1) Medicaid recipients shall receive covered long-term
4026 care services through the managed long-term care component
4027 unless excluded pursuant to s. 409.964. In order to receive
4028 Medicaid long-term care services, Medicaid recipients who meet
4029 all of the following criteria may participate in the managed
4030 long-term care. The recipient must be:

4031 (a) Sixty-five years of age or older or eligible for

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4032 Medicaid by reason of a disability.

4033 (b) Determined by the Comprehensive Assessment Review and
4034 Evaluation for Long-Term Care Services (CARES) Program to meet
4035 the criteria for nursing facility care.

4036 (2) Medicaid recipients who are residing in a nursing home
4037 facility or enrolled in one of the following long-term care
4038 Medicaid waiver programs on the date managed long-term care
4039 plans becomes available in the recipient's region are eligible
4040 for the following long-term care programs if the programs are
4041 operational on that date:

4042 (a) The Assisted Living for the Frail Elderly Waiver.

4043 (b) The Aged and Disabled Adult Waiver.

4044 (c) The Adult Day Health Care Waiver.

4045 (d) The Consumer-Directed Care Program as described in s.
4046 409.221.

4047 (e) The Program of All-inclusive Care for the Elderly.

4048 (f) The Long-Term Care Community-Based Diversion Pilot
4049 Project as described in s. 430.705.

4050 (g) The Channeling Services Waiver for Frail Elders.

4051 (3) This part does not create an entitlement to any home
4052 and community-based services provided under the managed long-
4053 term care component.

4054 Section 49. Section 409.975, Florida Statutes, is created
4055 to read:

4056 409.975 Managed long-term care services.—

4057 (1) Qualified plans participating in the managed long-term
4058 care component of the Medicaid managed care program, at a
4059 minimum, shall cover the following services:

4060 (a) The services listed in s. 409.972.

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4061 (b) Nursing facility services.

4062 (c) Home and community-based services, including, but not
4063 limited to, assisted living facility services.

4064 (2) Services provided under this section must be medically
4065 necessary and provided in accordance with state and federal law.
4066 This section does not prevent the agency from adjusting fees,
4067 reimbursement rates, lengths of stay, number of visits, or
4068 number of services, or from making any other adjustments
4069 necessary to comply with the availability of funding and any
4070 limitations or directions provided in the General Appropriations
4071 Act, chapter 216, or s. 409.9022.

4072 Section 50. Section 409.976, Florida Statutes, is created
4073 to read:

4074 409.976 Qualified managed long-term care plans.-

4075 (1) For purposes of managed long-term care, qualified plans
4076 also include:

4077 (a) Entities who are qualified under 42 C.F.R. part 422 as
4078 Medicare Advantage Preferred Provider Organizations, Medicare
4079 Advantage Provider-sponsored Organizations, and Medicare
4080 Advantage Special Needs Plans. Such plans may participate in the
4081 managed long-term care component.

4082 (b) The Program of All-inclusive Care for the Elderly
4083 (PACE). Participation by PACE shall be pursuant to a contract
4084 with the agency and is not subject to the procurement
4085 requirements of this section. PACE plans may continue to provide
4086 services to recipients at such levels and enrollment caps as
4087 authorized by the General Appropriations Act.

4088 (2) The agency shall select qualified plans through the
4089 procurement described in s. 409.965. The agency shall notice the

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4090 invitation to negotiate by November 14, 2011.

4091 (3) In addition to the criteria established in s. 409.965,
4092 the agency shall give preference to the following factors in
4093 selecting qualified plans:

4094 (a) The plan's employment of executive managers having
4095 expertise and experience in serving aged and disabled persons
4096 who require long-term care.

4097 (b) The plan's establishment of a network of service
4098 providers dispersed throughout the region and in sufficient
4099 numbers to meet specific service standards established by the
4100 agency for a continuum of care, beginning from the provision of
4101 assistance with the activities of daily living at a recipient's
4102 home and the provision of other home and community-based care
4103 through the provision of nursing home care. These providers
4104 include:

- 4105 1. Adult day centers.
- 4106 2. Adult family care homes.
- 4107 3. Assisted living facilities.
- 4108 4. Health care services pools.
- 4109 5. Home health agencies.
- 4110 6. Homemaker and companion services.
- 4111 7. Community Care for the Elderly lead agencies.
- 4112 8. Nurse registries.
- 4113 9. Nursing homes.

4114

4115 All providers are not required to be located within the region;
4116 however, the provider network must be sufficient to ensure that
4117 services are available throughout the region.

4118 (c) Whether a plan offers consumer-directed care services

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4119 to enrollees pursuant to s. 409.221 or includes attendant care
4120 or paid family caregivers in the benefit package. Consumer-
4121 directed care services must provide a flexible budget, which is
4122 managed by enrollees and their families or representatives, and
4123 allows them to choose service providers, determine provider
4124 rates of payment, and direct the delivery of services to best
4125 meet their special long-term care needs. If all other factors
4126 are equal among competing qualified plans, the agency shall give
4127 preference to such plans.

4128 (d) Evidence that a qualified plan has written agreements
4129 or signed contracts or has made substantial progress in
4130 establishing relationships with providers before the plan
4131 submits a response.

4132 (e) The availability and accessibility of case managers in
4133 the plan and provider network.

4134 Section 51. Section 409.977, Florida Statutes, is created
4135 to read:

4136 409.977 Managed long-term plan and provider
4137 accountability.—In addition to the requirements of ss. 409.966
4138 and 409.967, plans and providers participating in managed long-
4139 term care must comply with specific standards established by the
4140 agency for the number, type, and regional distribution of the
4141 following providers in the plan's network, which must include:

- 4142 (1) Adult day centers.
4143 (2) Adult family care homes.
4144 (3) Assisted living facilities.
4145 (4) Health care services pools.
4146 (5) Home health agencies.
4147 (6) Homemaker and companion services.

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4148 (7) Community Care for the Elderly lead agencies.

4149 (8) Nurse registries.

4150 (9) Nursing homes.

4151 Section 52. Section 409.978, Florida Statutes, is created
4152 to read:

4153 409.978 CARES program screening; levels of care.—

4154 (1) The agency shall operate the Comprehensive Assessment
4155 and Review for Long-Term Care Services (CARES) preadmission
4156 screening program to ensure that only recipients whose
4157 conditions require long-term care services are enrolled in
4158 managed long-term care plans.

4159 (2) The agency shall operate the CARES program through an
4160 interagency agreement with the Department of Elderly Affairs.
4161 The agency, in consultation with the department, may contract
4162 for any function or activity of the CARES program, including any
4163 function or activity required by 42 C.F.R. part 483.20, relating
4164 to preadmission screening and review.

4165 (3) The CARES program shall determine if a recipient
4166 requires nursing facility care and, if so, assign the recipient
4167 to one of the following levels of care:

4168 (a) Level of care 1 consists of enrollees who require the
4169 constant availability of routine medical and nursing treatment
4170 and care, have a limited need for health-related care and
4171 services, are mildly medically or physically incapacitated, and
4172 cannot be managed at home due to inadequacy of home-based
4173 services.

4174 (b) Level of care 2 consists of enrollees who require the
4175 constant availability of routine medical and nursing treatment
4176 and care, and require extensive health-related care and services

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4177 because of mental or physical incapacitation. Current enrollees
4178 in home and community-based waiver programs for persons who are
4179 elderly or adults with physical disability, or both, who remain
4180 financially eligible for Medicaid are not required to meet new
4181 level-of-care criteria except for immediate placement in a
4182 nursing home.

4183 (c) Level of care 3 consists of enrollees residing in
4184 nursing homes, or needing immediate placement in a nursing home,
4185 and who have a priority score of 5 or above as determined by
4186 CARES.

4187 (4) For recipients whose nursing home stay is initially
4188 funded by Medicare and Medicare coverage is being terminated for
4189 lack of progress towards rehabilitation, CARES staff shall
4190 consult with the person determining the recipient's progress
4191 toward rehabilitation in order to ensure that the recipient is
4192 not being inappropriately disqualified from Medicare coverage.
4193 If, in their professional judgment, CARES staff believes that a
4194 Medicare beneficiary is still making progress, they may assist
4195 the Medicare beneficiary with appealing the disqualification
4196 from Medicare coverage. The CARES teams may review Medicare
4197 denials for coverage under this section only if it is determined
4198 that such reviews qualify for federal matching funds through
4199 Medicaid. The agency shall seek or amend federal waivers as
4200 necessary to implement this section.

4201 Section 53. Section 409.91207, Florida Statutes, is
4202 transferred, renumbered as section 409.985, Florida Statutes,
4203 and subsection (1) of that section is amended to read:

4204 409.985 ~~409.91207~~ Medical home pilot project.—

4205 (1) The agency shall develop a plan to implement a medical

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4206 home pilot project that uses ~~utilizes~~ primary care case
4207 management enhanced by medical home networks to provide
4208 coordinated and cost-effective care that is reimbursed on a fee-
4209 for-service basis and to compare the performance of the medical
4210 home networks with other existing Medicaid managed care models.
4211 The agency may ~~is authorized to~~ seek a federal Medicaid waiver
4212 or an amendment to any existing Medicaid waiver, except for the
4213 current 1115 Medicaid waiver authorized in s. 409.986 ~~409.91211~~,
4214 as needed, to develop the pilot project created in this section
4215 but must obtain approval of the Legislature before ~~prior to~~
4216 implementing the pilot project.

4217 Section 54. Section 409.91211, Florida Statutes, is
4218 transferred, renumbered as section 409.986, Florida Statutes,
4219 and paragraph (aa) of subsection (3) and paragraph (a) of
4220 subsection (4) of that section are amended, to read:

4221 409.986 ~~409.91211~~ Medicaid managed care pilot program.—

4222 (3) The agency shall have the following powers, duties, and
4223 responsibilities with respect to the pilot program:

4224 (aa) To implement a mechanism whereby Medicaid recipients
4225 who are already enrolled in a managed care plan or the MediPass
4226 program in the pilot areas are ~~shall be~~ offered the opportunity
4227 to change to capitated managed care plans on a staggered basis,
4228 as defined by the agency. All Medicaid recipients shall have 30
4229 days in which to make a choice of capitated managed care plans.
4230 Those Medicaid recipients who do not make a choice shall be
4231 assigned to a capitated managed care plan in accordance with
4232 paragraph (4) (a) and shall be exempt from s. 409.987 ~~409.9122~~.
4233 To facilitate continuity of care for a Medicaid recipient who is
4234 also a recipient of Supplemental Security Income (SSI), prior to

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4235 assigning the SSI recipient to a capitated managed care plan,
4236 the agency shall determine whether the SSI recipient has an
4237 ongoing relationship with a provider or capitated managed care
4238 plan, and, if so, the agency shall assign the SSI recipient to
4239 that provider or capitated managed care plan where feasible.
4240 Those SSI recipients who do not have such a provider
4241 relationship shall be assigned to a capitated managed care plan
4242 provider in accordance with paragraph (4) (a) and shall be exempt
4243 from s. 409.987 ~~409.9122~~.

4244 (4) (a) A Medicaid recipient in the pilot area who is not
4245 currently enrolled in a capitated managed care plan upon
4246 implementation is not eligible for services as specified in ss.
4247 409.905 and 409.906, for the amount of time that the recipient
4248 does not enroll in a capitated managed care network. If a
4249 Medicaid recipient has not enrolled in a capitated managed care
4250 plan within 30 days after eligibility, the agency shall assign
4251 the Medicaid recipient to a capitated managed care plan based on
4252 the assessed needs of the recipient as determined by the agency
4253 and the recipient shall be exempt from s. 409.987 ~~409.9122~~. When
4254 making assignments, the agency shall take into account the
4255 following criteria:

4256 1. A capitated managed care network has sufficient network
4257 capacity to meet the needs of members.

4258 2. The capitated managed care network has previously
4259 enrolled the recipient as a member, or one of the capitated
4260 managed care network's primary care providers has previously
4261 provided health care to the recipient.

4262 3. The agency has knowledge that the member has previously
4263 expressed a preference for a particular capitated managed care

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4264 network as indicated by Medicaid fee-for-service claims data,
4265 but has failed to make a choice.

4266 4. The capitated managed care network's primary care
4267 providers are geographically accessible to the recipient's
4268 residence.

4269 Section 55. Section 409.9122, Florida Statutes, is
4270 transferred, renumbered as section 409.987, and paragraph (a) of
4271 subsection (2) of that section is amended to read:

4272 409.987 ~~409.9122~~ Mandatory Medicaid managed care
4273 enrollment; programs and procedures.—

4274 (2) (a) The agency shall enroll all Medicaid recipients in a
4275 managed care plan or MediPass ~~all Medicaid recipients, except~~
4276 ~~those Medicaid recipients who are~~ in an institution, receiving
4277 a Medicaid nonpoverty medical subsidy, ~~enrolled in the Medicaid~~
4278 ~~medically needy Program;~~ or eligible for both Medicaid and
4279 Medicare. Upon enrollment, recipients may ~~individuals will be~~
4280 ~~able to~~ change their managed care option during the 90-day opt
4281 out period required by federal Medicaid regulations. The agency
4282 may ~~is authorized to~~ seek the necessary Medicaid state plan
4283 amendment to implement this policy. ~~However, to the extent~~

4284 1. If permitted by federal law, the agency may enroll ~~in a~~
4285 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt
4286 from mandatory managed care enrollment in a managed care plan or
4287 MediPass if, ~~provided that:~~

4288 a.1. ~~The~~ recipient's decision to enroll in a managed care
4289 plan or MediPass is voluntary;

4290 b.2. ~~If~~ The recipient chooses to enroll in a managed care
4291 plan, the agency has determined that the ~~managed care plan~~
4292 provides specific programs and services that ~~which~~ address the

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4293 special health needs of the recipient; and

4294 ~~c.3.~~ The agency receives the ~~any~~ necessary waivers from the
4295 federal Centers for Medicare and Medicaid Services.

4296 2. The agency shall develop rules to establish policies by
4297 which exceptions to the mandatory managed care enrollment
4298 requirement may be made on a case-by-case basis. The rules must
4299 ~~shall~~ include the specific criteria to be applied when
4300 determining ~~making a determination as to~~ whether to exempt a
4301 recipient from mandatory enrollment ~~in a managed care plan or~~
4302 ~~MediPass.~~

4303 3. School districts participating in the certified school
4304 match program pursuant to ss. 409.908(21) and 1011.70 shall be
4305 reimbursed by Medicaid, subject to the limitations of s.
4306 1011.70(1), for a Medicaid-eligible child participating in the
4307 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.
4308 409.9071, regardless of whether the child is enrolled in
4309 MediPass or a managed care plan. Managed care plans must ~~shall~~
4310 make a good faith effort to execute agreements with school
4311 districts regarding the coordinated provision of services
4312 authorized under s. 1011.70.

4313 4. County health departments delivering school-based
4314 services pursuant to ss. 381.0056 and 381.0057 shall be
4315 reimbursed by Medicaid for the federal share for a Medicaid-
4316 eligible child who receives Medicaid-covered services in a
4317 school setting, regardless of whether the child is enrolled in
4318 MediPass or a managed care plan. Managed care plans shall make a
4319 good faith effort to execute agreements with county health
4320 departments that coordinate the ~~regarding the coordinated~~
4321 provision of services to a Medicaid-eligible child. To ensure

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4322 continuity of care for Medicaid patients, the agency, the
4323 Department of Health, and the Department of Education shall
4324 develop procedures for ensuring that a student's managed care
4325 plan or MediPass provider receives information relating to
4326 services provided in accordance with ss. 381.0056, 381.0057,
4327 409.9071, and 1011.70.

4328 Section 56. Section 409.9123, Florida Statutes, is
4329 transferred and renumbered as section 409.988, Florida Statutes.

4330 Section 57. Section 409.9124, Florida Statutes, is
4331 transferred and renumbered as section 409.989.

4332 Section 58. Subsection (15) of section 430.04, Florida
4333 Statutes, is amended to read:

4334 430.04 Duties and responsibilities of the Department of
4335 Elderly Affairs.—The Department of Elderly Affairs shall:

4336 (15) Administer all Medicaid waivers and programs relating
4337 to elders and their appropriations. The waivers include, but are
4338 not limited to:

4339 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~
4340 ~~established in s. 430.502(7), (8), and (9).~~

4341 (a)~~(b)~~ The Assisted Living for the Frail Elderly Waiver.

4342 (b)~~(c)~~ The Aged and Disabled Adult Waiver.

4343 (c)~~(d)~~ The Adult Day Health Care Waiver.

4344 (d)~~(e)~~ The Consumer-Directed Care Plus Program as defined
4345 in s. 409.221.

4346 (e)~~(f)~~ The Program of All-inclusive Care for the Elderly.

4347 (f)~~(g)~~ The Long-Term Care Community-Based Diversion Pilot
4348 Project as described in s. 430.705.

4349 (g)~~(h)~~ The Channeling Services Waiver for Frail Elders.

4350

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4351 The department shall develop a transition plan for recipients
4352 receiving services under long-term care Medicaid waivers for
4353 elders or disabled adults on the date qualified plans become
4354 available in each recipient's region pursuant to s. 409.973(2)
4355 in order to enroll those recipients in qualified plans.

4356 Section 59. Section 430.2053, Florida Statutes, is amended
4357 to read:

4358 430.2053 Aging resource centers.-

4359 (1) The department, in consultation with the Agency for
4360 Health Care Administration and the Department of Children and
4361 Family Services, shall develop pilot projects for aging resource
4362 centers. ~~By October 31, 2004, the department, in consultation~~
4363 ~~with the agency and the Department of Children and Family~~
4364 ~~Services, shall develop an implementation plan for aging~~
4365 ~~resource centers and submit the plan to the Governor, the~~
4366 ~~President of the Senate, and the Speaker of the House of~~
4367 ~~Representatives. The plan must include qualifications for~~
4368 ~~designation as a center, the functions to be performed by each~~
4369 ~~center, and a process for determining that a current area agency~~
4370 ~~on aging is ready to assume the functions of an aging resource~~
4371 ~~center.~~

4372 ~~(2) Each area agency on aging shall develop, in~~
4373 ~~consultation with the existing community care for the elderly~~
4374 ~~lead agencies within their planning and service areas, a~~
4375 ~~proposal that describes the process the area agency on aging~~
4376 ~~intends to undertake to transition to an aging resource center~~
4377 ~~prior to July 1, 2005, and that describes the area agency's~~
4378 ~~compliance with the requirements of this section. The proposals~~
4379 ~~must be submitted to the department prior to December 31, 2004.~~

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4380 ~~The department shall evaluate all proposals for readiness and,~~
4381 ~~prior to March 1, 2005, shall select three area agencies on~~
4382 ~~aging which meet the requirements of this section to begin the~~
4383 ~~transition to aging resource centers. Those area agencies on~~
4384 ~~aging which are not selected to begin the transition to aging~~
4385 ~~resource centers shall, in consultation with the department and~~
4386 ~~the existing community care for the elderly lead agencies within~~
4387 ~~their planning and service areas, amend their proposals as~~
4388 ~~necessary and resubmit them to the department prior to July 1,~~
4389 ~~2005. The department may transition additional area agencies to~~
4390 ~~aging resource centers as it determines that area agencies are~~
4391 ~~in compliance with the requirements of this section.~~

4392 ~~(3) The Auditor General and the Office of Program Policy~~
4393 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
4394 ~~review and assess the department's process for determining an~~
4395 ~~area agency's readiness to transition to an aging resource~~
4396 ~~center.~~

4397 ~~(a) The review must, at a minimum, address the~~
4398 ~~appropriateness of the department's criteria for selection of an~~
4399 ~~area agency to transition to an aging resource center, the~~
4400 ~~instruments applied, the degree to which the department~~
4401 ~~accurately determined each area agency's compliance with the~~
4402 ~~readiness criteria, the quality of the technical assistance~~
4403 ~~provided by the department to an area agency in correcting any~~
4404 ~~weaknesses identified in the readiness assessment, and the~~
4405 ~~degree to which each area agency overcame any identified~~
4406 ~~weaknesses.~~

4407 ~~(b) Reports of these reviews must be submitted to the~~
4408 ~~appropriate substantive and appropriations committees in the~~

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4409 ~~Senate and the House of Representatives on March 1 and September~~
4410 ~~1 of each year until full transition to aging resource centers~~
4411 ~~has been accomplished statewide, except that the first report~~
4412 ~~must be submitted by February 1, 2005, and must address all~~
4413 ~~readiness activities undertaken through December 31, 2004. The~~
4414 ~~perspectives of all participants in this review process must be~~
4415 ~~included in each report.~~

4416 (2)~~(4)~~ The purposes of an aging resource center are ~~shall~~
4417 ~~be:~~

4418 (a) To provide Florida's elders and their families with a
4419 locally focused, coordinated approach to integrating information
4420 and referral for all available services for elders with the
4421 eligibility determination entities for state and federally
4422 funded long-term-care services.

4423 (b) To provide for easier access to long-term-care services
4424 by Florida's elders and their families by creating multiple
4425 access points to the long-term-care network that flow through
4426 one established entity with wide community recognition.

4427 (3)~~(5)~~ The duties of an aging resource center are to:

4428 (a) Develop referral agreements with local community
4429 service organizations, such as senior centers, existing elder
4430 service providers, volunteer associations, and other similar
4431 organizations, to better assist clients who do not need or do
4432 not wish to enroll in programs funded by the department or the
4433 agency. The referral agreements must also include a protocol,
4434 developed and approved by the department, which provides
4435 specific actions that an aging resource center and local
4436 community service organizations must take when an elder or an
4437 elder's representative seeking information on long-term-care

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4438 services contacts a local community service organization prior
4439 to contacting the aging resource center. The protocol shall be
4440 designed to ensure that elders and their families are able to
4441 access information and services in the most efficient and least
4442 cumbersome manner possible.

4443 (b) Provide an initial screening of all clients who request
4444 long-term-care services to determine whether the person would be
4445 most appropriately served through any combination of federally
4446 funded programs, state-funded programs, locally funded or
4447 community volunteer programs, or private funding for services.

4448 (c) Determine eligibility for the programs and services
4449 listed in subsection (9) ~~(11)~~ for persons residing within the
4450 geographic area served by the aging resource center and
4451 determine a priority ranking for services which is based upon
4452 the potential recipient's frailty level and likelihood of
4453 institutional placement without such services.

4454 (d) Manage the availability of financial resources for the
4455 programs and services listed in subsection (9) ~~(11)~~ for persons
4456 residing within the geographic area served by the aging resource
4457 center.

4458 (e) If ~~When~~ financial resources become available, refer a
4459 client to the most appropriate entity to begin receiving
4460 services. The aging resource center shall make referrals to lead
4461 agencies for service provision that ensure that individuals who
4462 are vulnerable adults in need of services pursuant to s.
4463 415.104(3)(b), or who are victims of abuse, neglect, or
4464 exploitation in need of immediate services to prevent further
4465 harm and are referred by the adult protective services program,
4466 are given primary consideration for receiving community-care-

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4467 for-the-elderly services in compliance with the requirements of
4468 s. 430.205(5) (a) and that other referrals for services are in
4469 compliance with s. 430.205(5) (b) .

4470 (f) Convene a work group to advise in the planning,
4471 implementation, and evaluation of the aging resource center. The
4472 work group shall be composed ~~comprised~~ of representatives of
4473 local service providers, Alzheimer's Association chapters,
4474 housing authorities, social service organizations, advocacy
4475 groups, representatives of clients receiving services through
4476 the aging resource center, and ~~any~~ other persons or groups as
4477 determined by the department. The aging resource center, in
4478 consultation with the work group, must develop annual program
4479 improvement plans that shall be submitted to the department for
4480 consideration. The department shall review each annual
4481 improvement plan and make recommendations on how to implement
4482 the components of the plan.

4483 (g) Enhance the existing area agency on aging in each
4484 planning and service area by integrating, ~~either~~ physically or
4485 virtually, the staff and services of the area agency on aging
4486 with the staff of the department's local CARES Medicaid ~~nursing~~
4487 ~~home~~ preadmission screening unit and a sufficient number of
4488 staff from the Department of Children and Family Services'
4489 Economic Self-Sufficiency Unit necessary to determine the
4490 financial eligibility for all persons age 60 and older residing
4491 within the area served by the aging resource center who ~~that~~ are
4492 seeking Medicaid services, Supplemental Security Income, and
4493 food assistance.

4494 (h) Assist clients who request long-term care services in
4495 being evaluated for eligibility for the long-term care managed

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4496 care component of the Medicaid managed care program as qualified
4497 plans become available in each of the regions pursuant to s.
4498 409.973(2).

4499 (i) Provide enrollment and coverage information to Medicaid
4500 managed long-term care enrollees as qualified plans become
4501 available in each of the regions pursuant to s. 409.973(2).

4502 (j) Assist enrollees in the Medicaid long-term care managed
4503 care program with informally resolving grievances with a managed
4504 care network and in accessing the managed care network's formal
4505 grievance process as qualified plans become available in each of
4506 the regions pursuant to s. 409.973(2).

4507 (4)~~(6)~~ The department shall select the entities to become
4508 aging resource centers based on each entity's readiness and
4509 ability to perform the duties listed in subsection (3) ~~(5)~~ and
4510 the entity's:

4511 (a) Expertise in the needs of each target population the
4512 center proposes to serve and a thorough knowledge of the
4513 providers that serve these populations.

4514 (b) Strong connections to service providers, volunteer
4515 agencies, and community institutions.

4516 (c) Expertise in information and referral activities.

4517 (d) Knowledge of long-term-care resources, including
4518 resources designed to provide services in the least restrictive
4519 setting.

4520 (e) Financial solvency and stability.

4521 (f) Ability to collect, monitor, and analyze data in a
4522 timely and accurate manner, along with systems that meet the
4523 department's standards.

4524 (g) Commitment to adequate staffing by qualified personnel

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4525 to effectively perform all functions.

4526 (h) Ability to meet all performance standards established
4527 by the department.

4528 (5)~~(7)~~ The aging resource center shall have a governing
4529 body which shall be the same entity described in s. 20.41(7),
4530 and an executive director who may be the same person as
4531 described in s. 20.41(7). The governing body shall annually
4532 evaluate the performance of the executive director.

4533 (6)~~(8)~~ The aging resource center may not be a provider of
4534 direct services other than information and referral services,
4535 and screening.

4536 (7)~~(9)~~ The aging resource center must agree to allow the
4537 department to review any financial information the department
4538 determines is necessary for monitoring or reporting purposes,
4539 including financial relationships.

4540 (8)~~(10)~~ The duties and responsibilities of the community
4541 care for the elderly lead agencies within each area served by an
4542 aging resource center shall be to:

4543 (a) Develop strong community partnerships to maximize the
4544 use of community resources for the purpose of assisting elders
4545 to remain in their community settings for as long as it is
4546 safely possible.

4547 (b) Conduct comprehensive assessments of clients that have
4548 been determined eligible and develop a care plan consistent with
4549 established protocols that ensures that the unique needs of each
4550 client are met.

4551 (9)~~(11)~~ The services to be administered through the aging
4552 resource center shall include those funded by the following
4553 programs:

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- 4554 (a) Community care for the elderly.
4555 (b) Home care for the elderly.
4556 (c) Contracted services.
4557 (d) Alzheimer's disease initiative.
4558 (e) Aged and disabled adult Medicaid waiver.
4559 (f) Assisted living for the frail elderly Medicaid waiver.
4560 (g) Older Americans Act.
4561 (10)~~(12)~~ The department shall, prior to designation of an
4562 aging resource center, develop by rule operational and quality
4563 assurance standards and outcome measures to ensure that clients
4564 receiving services through all long-term-care programs
4565 administered through an aging resource center are receiving the
4566 appropriate care they require and that contractors and
4567 subcontractors are adhering to the terms of their contracts and
4568 are acting in the best interests of the clients they are
4569 serving, consistent with the intent of the Legislature to reduce
4570 the use of and cost of nursing home care. The department shall
4571 by rule provide operating procedures for aging resource centers,
4572 which shall include:
4573 (a) Minimum standards for financial operation, including
4574 audit procedures.
4575 (b) Procedures for monitoring and sanctioning of service
4576 providers.
4577 (c) Minimum standards for technology utilized by the aging
4578 resource center.
4579 (d) Minimum staff requirements which shall ensure that the
4580 aging resource center employs sufficient quality and quantity of
4581 staff to adequately meet the needs of the elders residing within
4582 the area served by the aging resource center.

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4583 (e) Minimum accessibility standards, including hours of
4584 operation.

4585 (f) Minimum oversight standards for the governing body of
4586 the aging resource center to ensure its continuous involvement
4587 in, and accountability for, all matters related to the
4588 development, implementation, staffing, administration, and
4589 operations of the aging resource center.

4590 (g) Minimum education and experience requirements for
4591 executive directors and other executive staff positions of aging
4592 resource centers.

4593 (h) Minimum requirements regarding any executive staff
4594 positions that the aging resource center must employ and minimum
4595 requirements that a candidate must meet in order to be eligible
4596 for appointment to such positions.

4597 (11) ~~(13)~~ In an area in which the department has designated
4598 an area agency on aging as an aging resource center, the
4599 department and the agency may ~~shall~~ not make payments for the
4600 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
4601 Community Diversion Project for ~~such~~ persons who were not
4602 screened and enrolled through the aging resource center. The
4603 department shall cease making these payments for enrollees in
4604 qualified plans as qualified plans become available in each of
4605 the regions pursuant to s. 409.973(2).

4606 (12) ~~(14)~~ Each aging resource center shall enter into a
4607 memorandum of understanding with the department for
4608 collaboration with the CARES unit staff. The memorandum of
4609 understanding must ~~shall~~ outline the staff person responsible
4610 for each function and ~~shall~~ provide the staffing levels
4611 necessary to carry out the functions of the aging resource

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4612 center.

4613 (13)~~(15)~~ Each aging resource center shall enter into a
4614 memorandum of understanding with the Department of Children and
4615 Family Services for collaboration with the Economic Self-
4616 Sufficiency Unit staff. The memorandum of understanding must
4617 ~~shall~~ outline which staff persons are responsible for which
4618 functions and ~~shall~~ provide the staffing levels necessary to
4619 carry out the functions of the aging resource center.

4620 (14)~~(16)~~ If any of the state activities described in this
4621 section are outsourced, ~~either~~ in part or in whole, the contract
4622 executing the outsourcing must ~~shall~~ mandate that the contractor
4623 or its subcontractors shall, ~~either~~ physically or virtually,
4624 execute the provisions of the memorandum of understanding
4625 instead of the state entity whose function the contractor or
4626 subcontractor now performs.

4627 (15)~~(17)~~ In order to be eligible to begin transitioning to
4628 an aging resource center, an area agency on aging board must
4629 ensure that the area agency on aging which it oversees meets all
4630 of the minimum requirements set by law and in rule.

4631 ~~(18) The department shall monitor the three initial~~
4632 ~~projects for aging resource centers and report on the progress~~
4633 ~~of those projects to the Governor, the President of the Senate,~~
4634 ~~and the Speaker of the House of Representatives by June 30,~~
4635 ~~2005. The report must include an evaluation of the~~
4636 ~~implementation process.~~

4637 (16)~~(19)~~ (a) Once an aging resource center is operational,
4638 the department, in consultation with the agency, may develop
4639 capitation rates for any of the programs administered through
4640 the aging resource center. Capitation rates for programs must

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4641 shall be based on the historical cost experience of the state in
4642 providing those same services to the population age 60 or older
4643 residing within each area served by an aging resource center.
4644 Each capitated rate may vary by geographic area as determined by
4645 the department.

4646 (b) The department and the agency may determine for each
4647 area served by an aging resource center whether it is
4648 appropriate, consistent with federal and state laws and
4649 regulations, to develop and pay separate capitated rates for
4650 each program administered through the aging resource center or
4651 to develop and pay capitated rates for service packages which
4652 include more than one program or service administered through
4653 the aging resource center.

4654 (c) Once capitation rates have been developed and certified
4655 as actuarially sound, the department and the agency may pay
4656 service providers the capitated rates for services if ~~when~~
4657 appropriate.

4658 (d) The department, in consultation with the agency, shall
4659 annually reevaluate and recertify the capitation rates,
4660 adjusting forward to account for inflation, programmatic
4661 changes.

4662 ~~(20) The department, in consultation with the agency, shall~~
4663 ~~submit to the Governor, the President of the Senate, and the~~
4664 ~~Speaker of the House of Representatives, by December 1, 2006, a~~
4665 ~~report addressing the feasibility of administering the following~~
4666 ~~services through aging resource centers beginning July 1, 2007:~~

4667 ~~(a) Medicaid nursing home services.~~

4668 ~~(b) Medicaid transportation services.~~

4669 ~~(c) Medicaid hospice care services.~~

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4670 ~~(d) Medicaid intermediate care services.~~
4671 ~~(e) Medicaid prescribed drug services.~~
4672 ~~(f) Medicaid assistive care services.~~
4673 ~~(g) Any other long term care program or Medicaid service.~~
4674 (17)~~(21)~~ This section does ~~shall~~ not be construed to allow
4675 an aging resource center to restrict, manage, or impede the
4676 local fundraising activities of service providers.

4677 Section 60. Paragraphs (c) and (d) of subsection (3) of
4678 section 39.407, Florida Statutes, are amended to read:

4679 39.407 Medical, psychiatric, and psychological examination
4680 and treatment of child; physical, mental, or substance abuse
4681 examination of person with or requesting child custody.—

4682 (3)

4683 (c) Except as provided in paragraphs (b) and (e), the
4684 department must file a motion seeking the court's authorization
4685 to initially provide or continue to provide psychotropic
4686 medication to a child in its legal custody. The motion must be
4687 supported by a written report prepared by the department which
4688 describes the efforts made to enable the prescribing physician
4689 to obtain express and informed consent to provide ~~for providing~~
4690 the medication to the child and other treatments considered or
4691 recommended for the child. ~~In addition,~~ The motion must also be
4692 supported by the prescribing physician's signed medical report
4693 providing:

4694 1. The name of the child, the name and range of the dosage
4695 of the psychotropic medication, and the ~~that there is a~~ need to
4696 prescribe psychotropic medication to the child based upon a
4697 diagnosed condition for which such medication is being
4698 prescribed.

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4699 2. A statement indicating that the physician has reviewed
4700 all medical information concerning the child which has been
4701 provided.

4702 3. A statement indicating that the psychotropic medication,
4703 at its prescribed dosage, is appropriate for treating the
4704 child's diagnosed medical condition, as well as the behaviors
4705 and symptoms the medication, at its prescribed dosage, is
4706 expected to address.

4707 4. An explanation of the nature and purpose of the
4708 treatment; the recognized side effects, risks, and
4709 contraindications of the medication; drug-interaction
4710 precautions; the possible effects of stopping the medication;
4711 and how the treatment will be monitored, followed by a statement
4712 indicating that this explanation was provided to the child if
4713 age appropriate and to the child's caregiver.

4714 5. Documentation addressing whether the psychotropic
4715 medication will replace or supplement any other currently
4716 prescribed medications or treatments; the length of time the
4717 child is expected to be taking the medication; and any
4718 additional medical, mental health, behavioral, counseling, or
4719 other services that the prescribing physician recommends.

4720 6. For a child 10 years of age or younger who is in an out-
4721 of-home placement, the results of a review of the administration
4722 of the medication by a child psychiatrist who is licensed under
4723 chapter 458 or chapter 459. The review must be provided to the
4724 child and the parent or legal guardian before final express and
4725 informed consent is given. The review must include a
4726 determination of the following:

4727 a. The presence of a genetic psychiatric disorder or a

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4728 family history of a psychiatric disorder;

4729 b. Whether the cause of a psychiatric disorder is organic
4730 or environmental; and

4731 c. The likelihood of the child being an imminent danger to
4732 self or others.

4733 (d)~~1~~. The department must notify all parties of the
4734 proposed action taken under paragraph (c) in writing or by
4735 whatever other method best ensures that all parties receive
4736 notification of the proposed action within 48 hours after the
4737 motion is filed. If any party objects to the department's
4738 motion, that party shall file the objection within 2 working
4739 days after being notified of the department's motion. If any
4740 party files an objection to the authorization of the proposed
4741 psychotropic medication, the court shall hold a hearing as soon
4742 as possible before authorizing the department to initially
4743 provide or to continue providing psychotropic medication to a
4744 child in the legal custody of the department.

4745 1. At such hearing and notwithstanding s. 90.803, the
4746 medical report described in paragraph (c) is admissible in
4747 evidence. The prescribing physician need not attend the hearing
4748 or testify unless the court specifically orders such attendance
4749 or testimony, or a party subpoenas the physician to attend the
4750 hearing or provide testimony.

4751 2. If, after considering any testimony received, the court
4752 finds that the department's motion and the physician's medical
4753 report meet the requirements of this subsection and that it is
4754 in the child's best interests, the court may order that the
4755 department provide or continue to provide the psychotropic
4756 medication to the child without additional testimony or

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4757 evidence.

4758 3. At any hearing held under this paragraph, the court
4759 shall ~~further~~ inquire of the department as to whether additional
4760 medical, mental health, behavioral, counseling, or other
4761 services are being provided to the child by the department which
4762 the prescribing physician considers to be necessary or
4763 beneficial in treating the child's medical condition and which
4764 the physician recommends or expects to provide to the child in
4765 concert with the medication. The court may order additional
4766 medical consultation, including consultation with the MedConsult
4767 line at the University of Florida, if available, or require the
4768 department to obtain a second opinion within a reasonable
4769 timeframe as established by the court, not to exceed 21 calendar
4770 days, ~~after such order~~ based upon consideration of the best
4771 interests of the child. The department must make a referral for
4772 an appointment for a second opinion with a physician within 1
4773 working day.

4774 4. The court may not order the discontinuation of
4775 prescribed psychotropic medication if such order is contrary to
4776 the decision of the prescribing physician unless the court first
4777 obtains an opinion from a licensed psychiatrist, if available,
4778 or, if not available, a physician licensed under chapter 458 or
4779 chapter 459, stating that more likely than not, discontinuing
4780 the medication would not cause significant harm to the child.
4781 If, however, the prescribing psychiatrist specializes in mental
4782 health care for children and adolescents, the court may not
4783 order the discontinuation of prescribed psychotropic medication
4784 unless the required opinion is also from a psychiatrist who
4785 specializes in mental health care for children and adolescents.

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4786 The court may also order the discontinuation of prescribed
4787 psychotropic medication if a child's treating physician,
4788 licensed under chapter 458 or chapter 459, states that
4789 continuing the prescribed psychotropic medication would cause
4790 significant harm to the child due to a diagnosed nonpsychiatric
4791 medical condition.

4792 5. If a child who is in out-of-home placement is 10 years
4793 of age or younger, psychotropic medication may not be authorized
4794 by the court absent a finding of a compelling governmental
4795 interest. In making such finding, the court shall review the
4796 psychiatric review described in subparagraph (c)6.

4797 6.2. The burden of proof at any hearing held under this
4798 paragraph shall be by a preponderance of the evidence.

4799 Section 61. Section 400.023, Florida Statutes, is reordered
4800 and amended to read:

4801 400.023 Civil enforcement.—

4802 (1) A Any resident who whose alleges negligence or a
4803 violation of rights as specified in this part has are violated
4804 shall have a cause of action against the licensee or its
4805 management company, as identified in the state application for
4806 nursing home licensure. However, the cause of action may not be
4807 asserted individually against an officer, director, owner,
4808 including an owner designated as having a controlling interest
4809 on the state application for nursing home licensure, or agent of
4810 a licensee or management company unless, following an
4811 evidentiary hearing, the court determines there is sufficient
4812 evidence in the record or proffered by the claimant which
4813 establishes a reasonable basis for finding that the person or
4814 entity breached, failed to perform, or acted outside the scope

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4815 of duties as an officer, director, owner, or agent, and that the
4816 breach, failure to perform, or action outside the scope of
4817 duties is a legal cause of actual loss, injury, death, or damage
4818 to the resident.

4819 (2) The action may be brought by the resident or his or her
4820 guardian, by a person or organization acting on behalf of a
4821 resident with the consent of the resident or his or her
4822 guardian, or by the personal representative of the estate of a
4823 deceased resident regardless of the cause of death.

4824 (5) If the action alleges a claim for the resident's rights
4825 or for negligence that:

4826 (a) Caused the death of the resident, the claimant must
4827 ~~shall be required to~~ elect ~~either~~ survival damages pursuant to
4828 s. 46.021 or wrongful death damages pursuant to s. 768.21. If
4829 the claimant elects wrongful death damages, total noneconomic
4830 damages may not exceed \$250,000, regardless of the number of
4831 claimants.

4832 ~~(b) If the action alleges a claim for the resident's rights~~
4833 ~~or for negligence that~~ Did not cause the death of the resident,
4834 the personal representative of the estate may recover damages
4835 for the negligence that caused injury to the resident.

4836 (3) The action may be brought in any court of competent
4837 jurisdiction to enforce such rights and to recover actual and
4838 punitive damages for any violation of the rights of a resident
4839 or for negligence.

4840 (10) Any resident who prevails in seeking injunctive relief
4841 or a claim for an administrative remedy may ~~is entitled to~~
4842 recover the costs of the action, and a reasonable attorney's fee
4843 assessed against the defendant not to exceed \$25,000. Fees shall

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4844 be awarded solely for the injunctive or administrative relief
4845 and not for any claim or action for damages whether such claim
4846 or action is brought together with a request for an injunction
4847 or administrative relief or as a separate action, except as
4848 provided under s. 768.79 or the Florida Rules of Civil
4849 Procedure. Sections 400.023-400.0238 provide the exclusive
4850 remedy for a cause of action for recovery of damages for the
4851 personal injury or death of a nursing home resident arising out
4852 of negligence or a violation of rights specified in s. 400.022.
4853 This section does not preclude theories of recovery not arising
4854 out of negligence or s. 400.022 which are available to a
4855 resident or to the agency. The provisions of chapter 766 do not
4856 apply to any cause of action brought under ss. 400.023-400.0238.

4857 (6)~~(2)~~ If the ~~In any~~ claim brought pursuant to this part
4858 alleges ~~alleging~~ a violation of resident's rights or negligence
4859 causing injury to or the death of a resident, the claimant shall
4860 have the burden of proving, by a preponderance of the evidence,
4861 that:

4862 (a) The defendant owed a duty to the resident;

4863 (b) The defendant breached the duty to the resident;

4864 (c) The breach of the duty is a legal cause of loss,
4865 injury, death, or damage to the resident; and

4866 (d) The resident sustained loss, injury, death, or damage
4867 as a result of the breach.

4868 (12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~
4869 create strict liability. A violation of the rights set forth in
4870 s. 400.022 or in any other standard or guidelines specified in
4871 this part or in any applicable administrative standard or
4872 guidelines of this state or a federal regulatory agency is ~~shall~~

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4873 ~~be~~ evidence of negligence but may ~~shall~~ not be considered
4874 negligence per se.

4875 (7)~~(3)~~ In any claim brought pursuant to this section, a
4876 licensee, person, or entity has ~~shall have~~ a duty to exercise
4877 reasonable care. Reasonable care is that degree of care which a
4878 reasonably careful licensee, person, or entity would use under
4879 like circumstances.

4880 (9)~~(4)~~ In any claim for resident's rights violation or
4881 negligence by a nurse licensed under part I of chapter 464, such
4882 nurse has a ~~shall have the~~ duty to exercise care consistent with
4883 the prevailing professional standard of care for a nurse. The
4884 prevailing professional standard of care for a nurse is ~~shall be~~
4885 that level of care, skill, and treatment which, in light of all
4886 relevant surrounding circumstances, is recognized as acceptable
4887 and appropriate by reasonably prudent similar nurses.

4888 (8)~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical
4889 negligence of any physician rendering care or treatment to the
4890 resident except for the administrative services of a medical
4891 director as required in this part. ~~Nothing in~~ This subsection
4892 does not ~~shall be construed to~~ protect a licensee, person, or
4893 entity from liability for failure to provide a resident with
4894 appropriate observation, assessment, nursing diagnosis,
4895 planning, intervention, and evaluation of care by nursing staff.

4896 (4)~~(6)~~ The resident or the resident's legal representative
4897 shall serve a copy of any complaint alleging in whole or in part
4898 a violation of any rights specified in this part to the agency
4899 ~~for Health Care Administration~~ at the time of filing the initial
4900 complaint with the clerk of the court for the county in which
4901 the action is pursued. ~~The requirement of~~ Providing a copy of

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4902 the complaint to the agency does not impair the resident's legal
4903 rights or ability to seek relief for his or her claim.

4904 ~~(11)(7)~~ An action under this part for a violation of rights
4905 or negligence ~~recognized herein~~ is not a claim for medical
4906 malpractice, and the provisions of s. 768.21(8) do not apply to
4907 a claim alleging death of the resident.

4908 Section 62. Subsections (1), (2), and (3) of section
4909 400.0237, Florida Statutes, are amended to read:

4910 400.0237 Punitive damages; pleading; burden of proof.—

4911 (1) In any action ~~for damages~~ brought under this part, a ~~no~~
4912 claim for punitive damages is not shall be permitted unless,
4913 based on admissible ~~there is a reasonable showing by evidence in~~
4914 ~~the record or~~ proffered by the claimant, which would provide a
4915 reasonable basis for recovery of such damages is demonstrated
4916 upon applying the criteria set forth in this section. The
4917 defendant may proffer admissible evidence to refute the
4918 claimant's proffer of evidence to recover punitive damages. The
4919 trial judge shall conduct an evidentiary hearing and weigh the
4920 admissible evidence proffered by the claimant and the defendant
4921 to ensure that there is a reasonable basis to believe that the
4922 claimant, at trial, will be able to demonstrate by clear and
4923 convincing evidence that the recovery of such damages is
4924 warranted. The claimant may move to amend her or his complaint
4925 to assert a claim for punitive damages as allowed by the rules
4926 of civil procedure. ~~The rules of civil procedure shall be~~
4927 ~~liberally construed so as to allow the claimant discovery of~~
4928 ~~evidence which appears reasonably calculated to lead to~~
4929 ~~admissible evidence on the issue of punitive damages. No~~
4930 Discovery of financial worth may not shall proceed until after

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4931 the trial judge approves the pleading on concerning punitive
4932 damages ~~is permitted~~.

4933 (2) A defendant, including the licensee or management
4934 company, against whom punitive damages is sought may be held
4935 liable for punitive damages only if the trier of fact, based on
4936 clear and convincing evidence, finds that a specific individual
4937 or corporate defendant actively and knowingly participated in
4938 intentional misconduct, or engaged in conduct that constituted
4939 gross negligence, and that conduct contributed to the loss,
4940 damages, or injury suffered by the claimant ~~the defendant was~~
4941 ~~personally guilty of intentional misconduct or gross negligence.~~
4942 As used in this section, the term:

4943 (a) "Intentional misconduct" means that the defendant
4944 against whom a claim for punitive damages is sought had actual
4945 knowledge of the wrongfulness of the conduct and the high
4946 probability that injury or damage to the claimant would result
4947 and, despite that knowledge, intentionally pursued that course
4948 of conduct, resulting in injury or damage.

4949 (b) "Gross negligence" means that the defendant's conduct
4950 was so reckless or wanting in care that it constituted a
4951 conscious disregard or indifference to the life, safety, or
4952 rights of persons exposed to such conduct.

4953 (3) In the case of vicarious liability of an employer,
4954 principal, corporation, or other legal entity, punitive damages
4955 may not be imposed for the conduct of an identified employee or
4956 agent unless ~~only if~~ the conduct of the employee or agent meets
4957 the criteria specified in subsection (2) and officers,
4958 directors, or managers of the actual employer corporation or
4959 legal entity condoned, ratified, or consented to the specific

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4960 conduct as alleged by the claimant in subsection (2).~~÷~~

4961 ~~(a) The employer, principal, corporation, or other legal~~
4962 ~~entity actively and knowingly participated in such conduct;~~

4963 ~~(b) The officers, directors, or managers of the employer,~~
4964 ~~principal, corporation, or other legal entity condoned,~~
4965 ~~ratified, or consented to such conduct; or~~

4966 ~~(c) The employer, principal, corporation, or other legal~~
4967 ~~entity engaged in conduct that constituted gross negligence and~~
4968 ~~that contributed to the loss, damages, or injury suffered by the~~
4969 ~~claimant.~~

4970 Section 63. Paragraphs (f), (h), (j), and (l) of subsection
4971 (1) and subsection (2) of section 409.1671, Florida Statutes,
4972 are amended to read:

4973 409.1671 Foster care and related services; outsourcing.—

4974 (1)

4975 (f)~~1~~. The Legislature finds that the state has
4976 traditionally provided foster care services to children who are
4977 ~~have been~~ the responsibility of the state. As such, foster
4978 children have not had the right to recover for injuries beyond
4979 the limitations specified in s. 768.28. The Legislature has also
4980 determined that foster care and related services need to be
4981 outsourced ~~pursuant to this section~~ and that the provision of
4982 such services is of paramount importance to the state. The
4983 purpose for such outsourcing is to increase the level of safety,
4984 security, and stability of children who are or become the
4985 responsibility of the state.

4986 1. One of the components necessary to secure a safe and
4987 stable environment for such children is for ~~that~~ private
4988 providers to maintain adequate liability insurance. ~~As Such,~~

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4989 insurance needs to be available and remain available to
4990 nongovernmental foster care and related services providers
4991 without the resources of such providers being significantly
4992 reduced by the cost of maintaining such insurance. To ensure
4993 that these resources are not significantly reduced, specified
4994 limits of liability are necessary for eligible lead community-
4995 based providers and subcontractors engaged in the provision of
4996 services previously performed by the department.

4997 2. The Legislature further finds that, by requiring the
4998 following minimum levels of insurance, children in outsourced
4999 foster care and related services will gain increased protection
5000 ~~and rights of recovery in the event of injury than provided for~~
5001 ~~in s. 768.28.~~

5002 (h) Other than an entity to which s. 768.28 applies, an any
5003 eligible lead community-based provider, ~~as defined in paragraph~~
5004 ~~(e),~~ or its employees or officers, except as otherwise provided
5005 in paragraph (i), must, as a part of its contract, obtain
5006 general liability coverage for a minimum of \$200,000 per claim
5007 or \$300,000 per incident ~~a minimum of \$1 million per claim/\$3~~
5008 ~~million per incident in general liability insurance coverage.~~

5009 1. The eligible lead community-based provider must also
5010 require ~~that~~ staff who transport client children and families in
5011 their personal automobiles in order to carry out their job
5012 responsibilities to obtain minimum bodily injury liability
5013 insurance on their personal automobiles in the amount of
5014 \$100,000 per claim or, \$300,000 per incident, ~~on their personal~~
5015 ~~automobiles.~~ In lieu of personal motor vehicle insurance, the
5016 lead community-based provider's casualty, liability, or motor
5017 vehicle insurance carrier may provide nonowned automobile

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5018 liability coverage. ~~This insurance provides liability insurance~~
 5019 for automobiles that the provider uses in connection with the
 5020 provider's business but does not own, lease, rent, or borrow.
 5021 This coverage includes automobiles owned by the employees of the
 5022 provider or a member of the employee's household ~~but only~~ while
 5023 the automobiles are used in connection with the provider's
 5024 business. The nonowned automobile coverage ~~for the provider~~
 5025 applies as excess coverage over any other collectible insurance.
 5026 The personal automobile policy for the employee of the provider
 5027 shall be primary insurance, and the nonowned automobile coverage
 5028 of the provider acts as excess insurance to the primary
 5029 insurance. The provider shall provide a minimum limit of \$1
 5030 million in nonowned automobile coverage.

5031 2. In any tort action brought against ~~such~~ an eligible lead
 5032 community-based provider or employee, net economic damages are
 5033 ~~shall be~~ limited to \$200,000 ~~\$1 million~~ per liability claim,
 5034 \$300,000 per liability incident, and \$100,000 per automobile
 5035 claim, including, but not limited to, past and future medical
 5036 expenses, wage loss, and loss of earning capacity, offset by any
 5037 collateral source payment paid or payable. In any tort action
 5038 brought against an eligible lead community-based provider, the
 5039 total economic damages recoverable by all claimants is limited
 5040 to \$500,000 in the aggregate. In any tort action brought against
 5041 such an eligible lead community-based provider, noneconomic
 5042 damages are ~~shall be~~ limited to \$200,000 per claim and \$300,000
 5043 per incident. In any tort action brought against an eligible
 5044 lead community-based provider, the total noneconomic damages
 5045 recoverable by all claimants are limited to \$500,000 in the
 5046 aggregate.

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5047 3. A claims bill may be brought on behalf of a claimant
5048 pursuant to s. 768.28 for any amount exceeding the limits
5049 specified in this paragraph. Any offset of collateral source
5050 payments made as of the date of the settlement or judgment shall
5051 be in accordance with s. 768.76. The lead community-based
5052 provider is ~~shall~~ not be liable in tort for the acts or
5053 omissions of its subcontractors or the officers, agents, or
5054 employees of its subcontractors.

5055 (j) Any subcontractor of an eligible lead community-based
5056 provider, ~~as defined in paragraph (e),~~ which is a direct
5057 provider of foster care and related services to children and
5058 families, and its employees or officers, except as otherwise
5059 provided in paragraph (i), must, as a part of its contract,
5060 obtain general liability insurance coverage for a minimum of
5061 \$200,000 per claim or \$300,000 ~~\$1 million per claim/\$3 million~~
5062 ~~per incident in general liability insurance coverage.~~

5063 1. The subcontractor of an eligible lead community-based
5064 provider must also require that staff who transport client
5065 children and families in their personal automobiles in order to
5066 carry out their job responsibilities obtain minimum bodily
5067 injury liability insurance in the amount of \$100,000 per claim,
5068 \$300,000 per incident, on their personal automobiles. In lieu of
5069 personal motor vehicle insurance, the subcontractor's casualty,
5070 liability, or motor vehicle insurance carrier may provide
5071 nonowned automobile liability coverage. This insurance provides
5072 liability insurance for automobiles that the subcontractor uses
5073 in connection with the subcontractor's business but does not
5074 own, lease, rent, or borrow. This coverage includes automobiles
5075 owned by the employees of the subcontractor or a member of the

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5076 employee's household but only while the automobiles are used in
5077 connection with the subcontractor's business. The nonowned
5078 automobile coverage for the subcontractor applies as excess
5079 coverage over any other collectible insurance. The personal
5080 automobile policy for the employee of the subcontractor is shall
5081 ~~be~~ primary insurance, and the nonowned automobile coverage of
5082 the subcontractor acts as excess insurance to the primary
5083 insurance. The subcontractor shall provide a minimum limit of \$1
5084 million in nonowned automobile coverage.

5085 2. In any tort action brought against such subcontractor or
5086 employee, net economic damages shall be limited to \$200,000 ~~\$1~~
5087 ~~million~~ per liability claim, \$300,000 per liability incident,
5088 and \$100,000 per automobile claim, including, but not limited
5089 to, past and future medical expenses, wage loss, and loss of
5090 earning capacity, offset by any collateral source payment paid
5091 or payable. In any tort action brought against such
5092 subcontractor or employee, the total economic damages
5093 recoverable by all claimants is limited to \$500,000 in the
5094 aggregate. In any tort action brought against such
5095 subcontractor, noneconomic damages shall be limited to \$200,000
5096 per claim and \$300,000 per incident. In any tort action brought
5097 against such subcontractor or employee, the total noneconomic
5098 damages recoverable by all claimants is limited to \$500,000 in
5099 the aggregate.

5100 3. A claims bill may be brought on behalf of a claimant
5101 pursuant to s. 768.28 for any amount exceeding the limits
5102 specified in this paragraph. Any offset of collateral source
5103 payments made as of the date of the settlement or judgment shall
5104 be in accordance with s. 768.76.

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5105 ~~(1) The Legislature is cognizant of the increasing costs of~~
5106 ~~goods and services each year and recognizes that fixing a set~~
5107 ~~amount of compensation actually has the effect of a reduction in~~
5108 ~~compensation each year. Accordingly, the conditional limitations~~
5109 ~~on damages in this section shall be increased at the rate of 5~~
5110 ~~percent each year, prorated from the effective date of this~~
5111 ~~paragraph to the date at which damages subject to such~~
5112 ~~limitations are awarded by final judgment or settlement.~~

5113 (2) ~~(a)~~ The department may contract for the delivery,
5114 administration, or management of protective services, the
5115 services specified in subsection (1) relating to foster care,
5116 and other related services or programs, as appropriate.

5117 (a) The department shall use diligent efforts to ensure
5118 that retain responsibility for the quality of contracted
5119 services and programs and shall ensure that services are of high
5120 quality and delivered in accordance with applicable federal and
5121 state statutes and regulations. However, the department is not
5122 liable in tort for the acts or omissions of eligible lead
5123 community-based providers or their officers, agents, or
5124 employees, or liable in tort for the acts or omissions of the
5125 subcontractors of eligible lead community-based care providers
5126 or their officers, agents, or employees. Further, the department
5127 may not require eligible lead community-based providers or their
5128 subcontractors to indemnify the department for the department's
5129 acts or omissions or require eligible lead-based community
5130 providers or their subcontractors to include the department as
5131 an additional insured on an insurance policy.

5132 (b) The department shall ~~must~~ adopt written policies and
5133 procedures for monitoring the contract for the delivery of

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5134 services by lead community-based providers. These policies and
5135 procedures must, at a minimum, address the evaluation of fiscal
5136 accountability and program operations, including provider
5137 achievement of performance standards, provider monitoring of
5138 subcontractors, and timely followup of corrective actions for
5139 significant monitoring findings related to providers and
5140 subcontractors. The ~~These~~ policies and procedures must also
5141 include provisions for reducing the duplication of the
5142 department's program monitoring activities both internally and
5143 with other agencies, to the extent possible. The department's
5144 written procedures must ensure that the written findings,
5145 conclusions, and recommendations from monitoring the contract
5146 ~~for services of lead community-based providers~~ are communicated
5147 to the director of the provider agency as expeditiously as
5148 possible.

5149 (c) ~~(b)~~ Persons employed by the department in the provision
5150 of foster care and related services whose positions are being
5151 outsourced under this statute shall be given hiring preference
5152 by the provider, if provider qualifications are met.

5153 Section 64. Section 458.3167, Florida Statutes, is created
5154 to read:

5155 458.3167 Expert witness certificate.-

5156 (1) A physician who holds an active and valid license to
5157 practice allopathic medicine in any other state or in Canada,
5158 who submits an application form prescribed by the board to
5159 obtain a certificate to provide expert testimony and pays the
5160 application fee, and who has not had a previous expert witness
5161 certificate revoked by the board shall be issued a certificate
5162 to provide expert testimony.

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5163 (2) A physician possessing an expert witness certificate
5164 may use the certificate only to give a verified written medical
5165 expert opinion as provided in s. 766.203 and to provide expert
5166 testimony concerning the prevailing professional standard of
5167 care for medical negligence litigation pending in this state
5168 against a physician licensed under this chapter or chapter 459.

5169 (3) An application for an expert witness certificate must
5170 be approved or denied within 5 business days after receipt of a
5171 completed application. An application that is not approved or
5172 denied within the required time period is deemed approved. An
5173 applicant seeking to claim certification by default shall notify
5174 the board, in writing, of the intent to rely on the default
5175 certification provision of this subsection. In such case, s.
5176 458.327 does not apply, and the applicant may provide expert
5177 testimony as provided in subsection (2).

5178 (4) All licensure fees, other than the initial certificate
5179 application fee, including the neurological injury compensation
5180 assessment, are waived for those persons obtaining an expert
5181 witness certificate. The possession of an expert witness
5182 certificate alone does not entitle the physician to engage in
5183 the practice of medicine as defined in s. 458.305.

5184 (5) The board shall adopt rules to administer this section,
5185 including rules setting the amount of the expert witness
5186 certificate application fee, which may not exceed \$50. An expert
5187 witness certificate expires 2 years after the date of issuance.

5188 Section 65. Subsection (11) is added to section 458.331,
5189 Florida Statutes, present paragraphs (oo) through (qq) of
5190 subsection (1) of that section are redesignated as paragraphs
5191 (pp) through (rr), respectively, and a new paragraph (oo) is

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5192 added to that subsection, to read:

5193 458.331 Grounds for disciplinary action; action by the
5194 board and department.—

5195 (1) The following acts constitute grounds for denial of a
5196 license or disciplinary action, as specified in s. 456.072(2):

5197 (oo) Providing misleading, deceptive, or fraudulent expert
5198 witness testimony related to the practice of medicine.

5199 (11) The purpose of this section is to facilitate uniform
5200 discipline for those acts made punishable under this section
5201 and, to this end, a reference to this section constitutes a
5202 general reference under the doctrine of incorporation by
5203 reference.

5204 Section 66. Section 459.0078, Florida Statutes, is created
5205 to read:

5206 459.0078 Expert witness certificate.—

5207 (1) A physician who holds an active and valid license to
5208 practice osteopathic medicine in any other state or in Canada,
5209 who submits an application form prescribed by the board to
5210 obtain a certificate to provide expert testimony and pays the
5211 application fee, and who has not had a previous expert witness
5212 certificate revoked by the board shall be issued a certificate
5213 to provide expert testimony.

5214 (2) A physician possessing an expert witness certificate
5215 may use the certificate only to give a verified written medical
5216 expert opinion as provided in s. 766.203 and to provide expert
5217 testimony concerning the prevailing professional standard of
5218 care for medical negligence litigation pending in this state
5219 against a physician licensed under this chapter or chapter 458.

5220 (3) An application for an expert witness certificate must

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5221 be approved or denied within 5 business days after receipt of a
5222 completed application. An application that is not approved or
5223 denied within the required time period is deemed approved. An
5224 applicant seeking to claim certification by default shall notify
5225 the board, in writing, of the intent to rely on the default
5226 certification provision of this subsection. In such case, s.
5227 459.013 does not apply, and the applicant may provide expert
5228 testimony as provided in subsection (2).

5229 (4) All licensure fees, other than the initial certificate
5230 application fee, including the neurological injury compensation
5231 assessment, are waived for those persons obtaining an expert
5232 witness certificate. The possession of an expert witness
5233 certificate alone does not entitle the physician to engage in
5234 the practice of osteopathic medicine as defined in s. 459.003.

5235 (5) The board shall adopt rules to administer this section,
5236 including rules setting the amount of the expert witness
5237 certificate application fee, which may not exceed \$50. An expert
5238 witness certificate expires 2 years after the date of issuance.

5239 Section 67. Subsection (11) is added to section 459.015,
5240 Florida Statutes, present paragraphs (qq) through (ss) of
5241 subsection (1) of that section are redesignated as paragraphs
5242 (rr) through (tt), respectively, and a new paragraph (qq) is
5243 added to that subsection, to read:

5244 459.015 Grounds for disciplinary action; action by the
5245 board and department.—

5246 (1) The following acts constitute grounds for denial of a
5247 license or disciplinary action, as specified in s. 456.072(2):

5248 (qq) Providing misleading, deceptive, or fraudulent expert
5249 witness testimony related to the practice of osteopathic

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5250 medicine.

5251 (11) The purpose of this section is to facilitate uniform
5252 discipline for those acts made punishable under this section
5253 and, to this end, a reference to this section constitutes a
5254 general reference under the doctrine of incorporation by
5255 reference.

5256 Section 68. Present subsection (12) of section 766.102,
5257 Florida Statutes, is redesignated as subsection (13), and a new
5258 subsection (12) is added to that section, to read:

5259 766.102 Medical negligence; standards of recovery; expert
5260 witness.—

5261 (12) If a physician licensed under chapter 458 or chapter
5262 459 is a party against whom, or on whose behalf, expert
5263 testimony about the prevailing professional standard of care is
5264 offered, the expert witness must otherwise meet the requirements
5265 of this section and be licensed as a physician under chapter 458
5266 or chapter 459, or must possess a valid expert witness
5267 certificate issued under s. 458.3167 or s. 459.0078.

5268 Section 69. Subsection (1) of section 766.104, Florida
5269 Statutes, is amended to read:

5270 766.104 Pleading in medical negligence cases; claim for
5271 punitive damages; authorization for release of records for
5272 investigation.—

5273 (1) An ~~No~~ action ~~shall be filed~~ for personal injury or
5274 wrongful death arising out of medical negligence, whether in
5275 tort or in contract, may not be filed unless the attorney filing
5276 the action has made a reasonable investigation, as permitted by
5277 the circumstances, to determine that there are grounds for a
5278 good faith belief that there has been negligence in the care or

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5279 treatment of the claimant.

5280 (a) The complaint or initial pleading must ~~shall~~ contain a
5281 certificate of counsel that such reasonable investigation gave
5282 rise to a good faith belief that grounds exist for an action
5283 against each named defendant. For purposes of this section, good
5284 faith may be shown ~~to exist~~ if the claimant or his or her
5285 counsel has received a written opinion, ~~which shall not be~~
5286 subject to discovery by an opposing party, of an expert as
5287 defined in s. 766.102 that there appears to be evidence of
5288 medical negligence. If the court determines that the ~~such~~
5289 certificate of counsel was not made in good faith and that no
5290 justiciable issue was presented against a health care provider
5291 that fully cooperated in providing informal discovery, the court
5292 shall award attorney's fees and taxable costs against claimant's
5293 counsel, ~~and shall~~ submit the matter to The Florida Bar for
5294 disciplinary review of the attorney.

5295 (b) If the cause of action requires the plaintiff to
5296 establish the breach of a standard of care other than negligence
5297 in order to impose liability or secure specified damages arising
5298 out of the rendering of, or the failure to render, medical care
5299 or services, and the plaintiff intends to pursue such liability
5300 or damages, the investigation and certification required by this
5301 subsection must demonstrate grounds for a good faith belief that
5302 the requirement is satisfied.

5303 Section 70. Subsection (5) of section 766.106, Florida
5304 Statutes, is amended to read:

5305 766.106 Notice before filing action for medical negligence;
5306 presuit screening period; offers for admission of liability and
5307 for arbitration; informal discovery; review.—

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5308 (5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion,
5309 written document, report, or other work product generated by the
5310 presuit screening process is discoverable or admissible in any
5311 civil action for any purpose by the opposing party. All
5312 participants, including, but not limited to, physicians,
5313 investigators, witnesses, and employees or associates of the
5314 defendant, are immune from civil liability arising from
5315 participation in the presuit screening process. This subsection
5316 does not prohibit a physician licensed under chapter 458 or
5317 chapter 459, or a physician who holds a certificate to provide
5318 expert testimony under s. 458.3167 or s. 459.0078, who submits a
5319 verified written expert medical opinion from being subject to
5320 disciplinary action pursuant to s. 456.073.

5321 Section 71. Subsection (11) of section 766.1115, Florida
5322 Statutes, is amended to read:

5323 766.1115 Health care providers; creation of agency
5324 relationship with governmental contractors.—

5325 (11) APPLICABILITY.—

5326 (a) This section applies to incidents occurring on or after
5327 April 17, 1992.

5328 (b) This section does not apply to any health care contract
5329 entered into by the Department of Corrections which is subject
5330 to s. 768.28(10)(a).

5331 (c) This section does not apply to any affiliation
5332 agreement or other contract subject to s. 768.28(10)(f).

5333 (d) ~~Nothing in~~ This section does not reduce or limit ~~in any~~
5334 ~~way reduces or limits~~ the rights of the state or any of its
5335 agencies or subdivisions to any benefit currently provided under
5336 s. 768.28.

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5337 Section 72. Section 766.1183, Florida Statutes, is created
5338 to read:

5339 766.1183 Standard of care for Medicaid providers.—

5340 (1) As used in this section:

5341 (a) The terms "applicant," "medical assistance," "medical
5342 services," and "Medicaid recipient" have the same meaning as in
5343 s. 409.901.

5344 (b) The term "provider" means a health care provider as
5345 defined in s. 766.202 or an entity that qualifies for an
5346 exemption under s. 400.9905(4) (e). The term includes:

5347 1. Any person or entity for whom a provider is vicariously
5348 liable; and

5349 2. Any person or entity whose liability is based solely on
5350 such person or entity being vicariously liable for the actions
5351 of a provider.

5352 (c) The term "wrongful manner" means in bad faith or with
5353 malicious purpose or in a manner exhibiting wanton and willful
5354 disregard of human rights, safety, or property, and shall be
5355 construed in conformity with the standard set forth in s.
5356 768.28(9) (a).

5357 (2) A provider is not liable in excess of \$200,000 per
5358 claimant or \$300,000 per occurrence for any cause of action
5359 arising out of the rendering of, or the failure to render,
5360 medical services to a Medicaid recipient, except as provided
5361 under subsection (3). However, a judgment may be claimed and
5362 rendered in excess of the amounts set forth in this subsection.
5363 That portion of the judgment that exceeds these amounts may be
5364 reported to the Legislature, but may be paid in part or in whole
5365 by the state only by further act of the Legislature.

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5366 (3) A provider may be liable for an amount in excess of
5367 \$200,000 per claimant or \$300,000 per occurrence only if the
5368 claimant pleads and proves, by clear and convincing evidence,
5369 that the provider acted in a wrongful manner. If the claimant so
5370 pleads, the court, after a reasonable opportunity for discovery,
5371 shall conduct a hearing before trial to determine if there is a
5372 reasonable basis in evidence to conclude that the provider acted
5373 in a wrongful manner. A claim for wrongful conduct is not
5374 permitted, to the extent it exceeds the amounts set forth in
5375 subsection (2), unless the claimant makes the showing required
5376 by this subsection.

5377 (4) At the time an application for medical assistance is
5378 submitted, the Department of Children and Family Services shall
5379 furnish the applicant with written notice of the provisions of
5380 this section.

5381 (5) This section does not limit or exclude the application
5382 of any law, including s. 766.118, which places limitations upon
5383 the recovery of civil damages.

5384 (6) This section does not apply to any claim for damages to
5385 which s. 768.28 applies.

5386 Section 73. Section 766.1184, Florida Statutes, is created
5387 to read:

5388 766.1184 Standard of care; low-income pool recipient.—

5389 (1) As used in this section, the term:

5390 (a) "Low-income pool recipient" means a low-income
5391 individual who is uninsured or underinsured and who receives
5392 primary care services from a provider which are delivered
5393 exclusively using funding received by that provider under
5394 proviso language accompanying specific appropriation 191 of the

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5395 2010-2011 fiscal year General Appropriations Act to establish
5396 new or expand existing primary care clinics for low-income
5397 persons who are uninsured or underinsured.

5398 (b) "Provider" means a health care provider, as defined in
5399 s. 766.202, which received funding under proviso language
5400 accompanying specific appropriation 191 of the fiscal year 2010-
5401 11 General Appropriations Act to establish new or expand
5402 existing primary care clinics for low-income persons who are
5403 uninsured or underinsured. The term includes:

5404 1. Any person or entity for whom the provider is
5405 vicariously liable; and

5406 2. Any person or entity whose liability is based solely on
5407 such person or entity being vicariously liable for the actions
5408 of the provider.

5409 (c) "Wrongful manner" means in bad faith or with malicious
5410 purpose or in a manner exhibiting wanton and willful disregard
5411 of human rights, safety, or property, and shall be construed in
5412 conformity with the standard set forth in s. 768.28(9)(a).

5413
5414 The funding of the provider's primary care clinic must have been
5415 awarded pursuant to a plan approved by the Legislative Budget
5416 Commission, and must be the subject of an agreement between the
5417 provider and the Agency for Health Care Administration,
5418 following the competitive solicitation of proposals to use low-
5419 income pool grant funds to provide primary care services in
5420 general acute hospitals, county health departments, faith-based
5421 and community clinics, and federally qualified health centers to
5422 uninsured or underinsured persons.

5423 (2) A provider is not liable in excess of \$200,000 per

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5424 claimant or \$300,000 per occurrence for any cause of action
5425 arising out of the rendering of, or the failure to render,
5426 primary care services to a low-income pool recipient, except as
5427 provided under subsection (3). However, a judgment may be
5428 claimed and rendered in excess of the amounts set forth in this
5429 subsection. That portion of the judgment that exceeds these
5430 amounts may be reported to the Legislature, but may be paid in
5431 part or in whole by the state only by further act of the
5432 Legislature.

5433 (3) A provider may be liable for an amount in excess of
5434 \$200,000 per claimant or \$300,000 per occurrence only if the
5435 claimant pleads and proves, by clear and convincing evidence,
5436 that the provider acted in a wrongful manner. If the claimant so
5437 pleads, the court, after a reasonable opportunity for discovery,
5438 shall conduct a hearing before trial to determine if there is a
5439 reasonable basis in evidence to conclude that the provider acted
5440 in a wrongful manner. A claim for wrongful conduct is not
5441 permitted, to the extent it exceeds the amounts set forth in
5442 subsection (2), unless the claimant makes the showing required
5443 by this subsection.

5444 (4) In order for this section to apply, the provider must:

5445 (a) Develop, implement, and maintain policies and
5446 procedures to:

5447 1. Ensure that funds described in subsection (1) are used
5448 exclusively to serve low-income persons who are uninsured or
5449 underinsured;

5450 2. Determine whether funds described in subsection (1) are
5451 being used to provide primary care services to a particular
5452 person; and

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5453 3. Identify whether an individual receiving primary care
5454 services is a low-income pool recipient to whom the provisions
5455 of this section apply.

5456 (b) Furnish a low-income pool recipient with written notice
5457 of the provisions of this section before providing primary care
5458 services to the recipient.

5459 (c) Be in compliance with the terms of any agreement
5460 between the provider and the Agency for Health Care
5461 Administration governing the receipt of the funds described in
5462 subsection (1).

5463 (5) This section does not limit or exclude the application
5464 of any law, including s. 766.118, which places limitations upon
5465 the recovery of civil damages.

5466 (6) This section does not apply to any claim for damages to
5467 which s. 768.28 applies.

5468 Section 74. Subsection (5) is added to section 766.203,
5469 Florida Statutes, to read:

5470 766.203 Presuit investigation of medical negligence claims
5471 and defenses by prospective parties.—

5472 (5) STANDARDS OF CARE.—If the cause of action that is the
5473 basis for the litigation requires the plaintiff to establish the
5474 breach of a standard of care other than negligence in order to
5475 impose liability or secure specified damages arising out of the
5476 rendering of, or the failure to render, medical care or
5477 services, and the plaintiff intends to pursue such liability or
5478 damages, the presuit investigations required of the claimant and
5479 the prospective defendant by this section must ascertain that
5480 there are reasonable grounds to believe that the requirement is
5481 satisfied.

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5482 Section 75. Paragraph (b) of subsection (9) of section
5483 768.28, Florida Statutes, is amended, and paragraph (f) is added
5484 to subsection (10) of that section, to read:

5485 768.28 Waiver of sovereign immunity in tort actions;
5486 recovery limits; limitation on attorney fees; statute of
5487 limitations; exclusions; indemnification; risk management
5488 programs.—

5489 (9)

5490 (b) As used in this subsection, the term:

5491 1. "Employee" includes any volunteer firefighter.

5492 2. "Officer, employee, or agent" includes, but is not
5493 limited to, any health care provider when providing services
5494 pursuant to s. 766.1115;~~;~~ any member of the Florida Health
5495 Services Corps, as defined in s. 381.0302, who provides
5496 uncompensated care to medically indigent persons referred by the
5497 Department of Health; any state not-for-profit college or
5498 university that owns or operates an accredited medical school
5499 and its employees or agents when providing services pursuant to
5500 paragraph (10) (f);~~;~~ and any public defender or her or his
5501 employee or agent, including, among others, an assistant public
5502 defender and an investigator.

5503 (10)

5504 (f) For purposes of this section, any state not-for-profit
5505 college or university that owns or operates an accredited
5506 medical school, or any of its employees or agents, and that has
5507 agreed in an affiliation agreement or other contract to provide,
5508 or permit its employees or agents to provide, patient services
5509 as agents of a teaching hospital is considered an agent of the
5510 teaching hospital while acting within the scope of and pursuant

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5511 to guidelines established in the contract. To the extent allowed
5512 by law, the contract must provide for the indemnification of the
5513 state, up to the limits set out in this chapter, by the agent
5514 for any liability incurred which was caused by the negligence of
5515 the college or university or its employees or agents.

5516 1. For purposes of this paragraph, the term:

5517 a. "Employee or agent" means an officer, employee, agent,
5518 or servant of a state not-for-profit college or university that
5519 owns or operates an accredited medical school, including, but
5520 not limited to, the faculty of the medical school, any health
5521 care practitioner or licensee as defined in s. 456.001 for which
5522 the college or university is vicariously liable, and the staff
5523 or administrator of the medical school.

5524 b. "Patient services" mean:

5525 (I) Comprehensive health care services as defined in s.
5526 641.19, including any related administrative service, provided
5527 to patients in a teaching hospital or in a health care facility
5528 owned by a state not-for-profit college or university that owns
5529 or operates an accredited medical school, pursuant to an
5530 affiliation agreement or other contract with a teaching
5531 hospital;

5532 (II) Training and supervision of interns, residents, and
5533 fellows providing patient services in a teaching hospital or in
5534 a health care facility owned by a state not-for-profit college
5535 or university that owns or operates an accredited medical
5536 school, pursuant to an affiliation agreement or other contract
5537 with a teaching hospital;

5538 (III) Participation in medical research protocols; or

5539 (IV) Training and supervision of medical students in a

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5540 teaching hospital or in a health care facility owned by a state
5541 not-for-profit college or university that owns or operates an
5542 accredited medical school, pursuant to an affiliation agreement
5543 or other contract with a teaching hospital.

5544 c. "Teaching hospital" means a teaching hospital as defined
5545 in s. 408.07 which is owned or operated by the state, a county
5546 or municipality, a public health trust, a special taxing
5547 district, a governmental entity having health care
5548 responsibilities, or a not-for-profit entity that operates such
5549 facilities as an agent of the state or a political subdivision
5550 of the state under a lease or other contract.

5551 2. The teaching hospital or the medical school, or its
5552 employees or agents, must provide written notice to each
5553 patient, or the patient's legal representative, receipt of which
5554 must be acknowledged in writing, that the college or university
5555 that owns or operates the medical school and the employees or
5556 agents of that college or university are acting as agents of the
5557 teaching hospital and that the exclusive remedy for injury or
5558 damage suffered as the result of any act or omission of the
5559 teaching hospital, the college or university that owns or
5560 operates the medical school, or the employees or agents of the
5561 college or university while acting within the scope of duties
5562 pursuant to the affiliation agreement or other contract with a
5563 teaching hospital is by commencement of an action pursuant to
5564 the provisions of this section.

5565 3. This paragraph does not designate any employee providing
5566 contracted patient services in a teaching hospital as an
5567 employee or agent of the state for purposes of chapter 440.

5568 Section 76. Legislative findings and intent.-

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5569 (1) The Legislature finds that:

5570 (a) Access to high quality, comprehensive, and affordable
5571 health care for all persons in this state is a necessary state
5572 goal, and that teaching hospitals play an intrinsic and
5573 essential role in providing that access.

5574 (b) Graduate medical education, provided by colleges and
5575 universities that own or operate private medical schools, helps
5576 provide the comprehensive specialty training needed by medical
5577 school graduates to develop and refine the skills essential to
5578 the provision of high quality health care for our state
5579 residents. Much of that education and training is provided in
5580 public teaching hospitals under the direct supervision of
5581 medical faculty employees who provide guidance, training, and
5582 oversight, and serve as role models to their students.

5583 (c) A large proportion of medical care is provided in large
5584 public teaching hospitals that serve as safety nets for many
5585 indigent and underserved patients who otherwise might not
5586 receive the medical help they need. Resident physician training
5587 that takes place in such hospitals provides much of the care
5588 provided to this population. Medical faculty, supervising such
5589 training and care, are a vital link between educating and
5590 training resident physicians and ensuring the provision of
5591 quality care for indigent and underserved residents. Physicians
5592 that assume this role are often called upon to juggle the
5593 demands of patient care, teaching, research, health policy, and
5594 budgetary issues related to the programs they administer.

5595 (d) The employees or agents of private colleges and
5596 universities that enter into affiliation agreements or contracts
5597 with public teaching hospitals to provide patient services do

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5598 not have the same level of protection against liability claims
5599 as public teaching hospitals and their employees and agents who
5600 provide the same patient services to the same patients. Thus,
5601 these private colleges and universities and their employees and
5602 agents are disproportionately affected by claims arising out of
5603 alleged medical malpractice and other allegedly negligent acts.
5604 Given the recent growth in medical schools and medical education
5605 programs and ongoing efforts to support, strengthen, and
5606 increase physician residency training positions and medical
5607 faculty in both existing and newly designated teaching
5608 hospitals, this exposure and the consequent disparity in
5609 liability exposure will continue to increase. The vulnerability
5610 of these colleges and universities to claims of medical
5611 malpractice will only add to the current physician workforce
5612 crisis in Florida, and can only be alleviated through
5613 legislative action.

5614 (e) Ensuring that the employees and agents of private
5615 colleges and universities that own or operated medical schools
5616 are able to continue to treat patients, provide graduate medical
5617 education, supervise medical students, engage in research, and
5618 provide administrative support and services in public teaching
5619 hospitals is an overwhelming public necessity.

5620 (2) The Legislature intends that:

5621 (a) Employees and agents of private colleges and
5622 universities that own or operate medical schools, who provide
5623 patient services as agents of a public teaching hospital be
5624 immune from lawsuits in the same manner and to the same extent
5625 as employees and agents of public teaching hospitals in this
5626 state under existing law, and that such colleges and

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5627 universities and their employees and agents not be held
5628 personally liable in tort or named as a party defendant in an
5629 action while providing patient services in a public teaching
5630 hospital, unless such services are provided in bad faith, with
5631 malicious purpose, or in a manner exhibiting wanton and willful
5632 disregard of human rights, safety, or property.

5633 (b) Private colleges and universities that own or operate
5634 medical schools and that permit their employees or agents to
5635 provide patient services in public teaching hospitals pursuant
5636 to an affiliation agreement or other contract, be afforded
5637 sovereign immunity protections under s. 768.28, Florida
5638 Statutes.

5639 (3) The Legislature declares that there is an overpowering
5640 public necessity for extending the state's sovereign immunity to
5641 private colleges and universities, and their employees or
5642 agents, which own or operate medical schools and provide medical
5643 services in public teaching hospitals, and that there is no
5644 alternative method of meeting such public necessity.

5645 Section 77. Section 1004.41, Florida Statutes, is amended
5646 to read:

5647 1004.41 University of Florida; J. Hillis Miller Health
5648 Center.—

5649 (1) There is established the J. Hillis Miller Health Center
5650 at the University of Florida, including campuses at Gainesville
5651 and Jacksonville and affiliated teaching hospitals, which shall
5652 include the following colleges:

5653 (a) College of Dentistry.

5654 (b) College of Public Health and Health Professions.

5655 (c) College of Medicine.

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5656 (d) College of Nursing.

5657 (e) College of Pharmacy.

5658 (f) College of Veterinary Medicine and related teaching
5659 hospitals.

5660 (2) Each college of the health center shall be ~~se~~
5661 maintained and operated so as to comply with the standards
5662 approved by a nationally recognized association for
5663 accreditation.

5664 (3) (a) The University of Florida Health Center Operations
5665 and Maintenance Trust Fund shall be administered by the
5666 University of Florida Board of Trustees. Funds shall be credited
5667 to the trust fund from the sale of goods and services performed
5668 by the University of Florida Veterinary Medicine Teaching
5669 Hospital. The purpose of the trust fund is to support the
5670 instruction, research, and service missions of the University of
5671 Florida College of Veterinary Medicine.

5672 (b) Notwithstanding ~~the provisions of~~ s. 216.301, and
5673 pursuant to s. 216.351, any balance in the trust fund at the end
5674 of any fiscal year shall remain in the trust fund and ~~shall~~ be
5675 available for carrying out the purposes of the trust fund.

5676 (4) (a) The University of Florida Board of Trustees shall
5677 lease the hospital facilities of the health center known as the
5678 Shands Teaching Hospital and Clinics on the Gainesville campus
5679 of the University of Florida and all furnishings, equipment, and
5680 other chattels or choses in action used in the operation of the
5681 hospital, to Shands Teaching Hospital and Clinics, Inc., a
5682 private not-for-profit corporation organized ~~solely~~ for the
5683 primary purpose of supporting operating the University of
5684 Florida Board of Trustees' health affairs mission of community

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5685 service and patient care, education and training of health
5686 professionals, and clinical research. In furtherance of that
5687 purpose, Shands Teaching Hospital and Clinics, Inc., shall
5688 operate the hospital and ancillary health care facilities as
5689 deemed of the health center and other health care facilities and
5690 programs determined to be necessary by the board of Shands
5691 Teaching Hospital and Clinics, Inc. the nonprofit corporation.
5692 The rental for the hospital facilities shall be an amount equal
5693 to the debt service on bonds or revenue certificates issued
5694 solely for capital improvements to the hospital facilities or as
5695 otherwise provided by law.

5696 (b) The University of Florida Board of Trustees shall
5697 provide in the lease or by separate contract or agreement with
5698 Shands Teaching Hospital and Clinics, Inc., the not-for-profit
5699 corporation for the following:

5700 1. Approval of the articles of incorporation of Shands
5701 Teaching Hospital and Clinics, Inc., the not-for-profit
5702 corporation by the University of Florida Board of Trustees and
5703 the governance of that the not-for-profit corporation by a board
5704 of directors appointed, subject to removal, and chaired by the
5705 President of the University of Florida, or his or her designee,
5706 and vice chaired by the Vice President for Health Affairs of the
5707 University of Florida, or his or her designee.

5708 2. The use of hospital facilities and personnel in support
5709 of community service and patient care, ~~the~~ research programs,
5710 and ~~of the teaching~~ roles ~~role~~ of the health center.

5711 3. The continued recognition of the collective bargaining
5712 units and collective bargaining agreements as currently composed
5713 and recognition of the certified labor organizations

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5714 representing those units and agreements.

5715 4. The use of hospital facilities and personnel in
5716 connection with research programs conducted by the health
5717 center.

5718 5. Reimbursement to the hospital for indigent patients,
5719 state-mandated programs, underfunded state programs, and costs
5720 to the hospital for support of the teaching and research
5721 programs of the health center. Such reimbursement shall be
5722 appropriated to either the health center or the hospital each
5723 year by the Legislature after review and approval of the request
5724 for funds.

5725 (c) The University of Florida Board of Trustees may, with
5726 the approval of the Legislature, increase the hospital
5727 facilities or remodel or renovate them, provided that the rental
5728 paid by the hospital for such new, remodeled, or renovated
5729 facilities is sufficient to amortize the costs thereof over a
5730 reasonable period of time or fund the debt service for any bonds
5731 or revenue certificates issued to finance such improvements.

5732 (d) The University of Florida Board of Trustees is
5733 authorized to provide to Shands Teaching Hospital and Clinics,
5734 Inc., ~~the not-for-profit corporation leasing the hospital~~
5735 ~~facilities~~ and its not-for-profit subsidiaries and affiliates
5736 comprehensive general liability insurance including professional
5737 liability from a self-insurance trust program established
5738 pursuant to s. 1004.24.

5739 (e) Shands Teaching Hospital and Clinics, Inc., may, in
5740 support of the health affairs mission of the University of
5741 Florida Board of Trustees and with its prior approval, create
5742 for-profit or not-for-profit corporate subsidiaries and

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5743 affiliates, or both. The University of Florida Board of
5744 Trustees, which may act through the President of the University
5745 of Florida or his or her designee, has the right to control
5746 Shands Teaching Hospital and Clinics, Inc. Shands Teaching
5747 Hospital and Clinics, Inc., and any not-for-profit subsidiaries
5748 are conclusively deemed corporations primarily acting as
5749 instrumentalities of the state, pursuant to s. 768.28(2), for
5750 purposes of sovereign immunity.

5751 (f)(e) If In the event that the lease of the hospital
5752 facilities to Shands Teaching Hospital and Clinics, Inc., the
5753 ~~not-for-profit corporation~~ is terminated for any reason, the
5754 University of Florida Board of Trustees shall resume management
5755 and operation of the hospital facilities. In such event, the
5756 University of Florida Board of Trustees is authorized to utilize
5757 revenues generated from the operation of the hospital facilities
5758 to pay the costs and expenses of operating the hospital facility
5759 for the remainder of the fiscal year in which such termination
5760 occurs.

5761 (5)(f) Shands Jacksonville Medical Center, Inc., and its
5762 parent Shands Jacksonville Healthcare, Inc., are private not-
5763 for-profit corporations organized primarily to support the
5764 health affairs mission of the University of Florida Board of
5765 Trustees in community service and patient care, education and
5766 training of health affairs professionals, and clinical research.
5767 Shands Jacksonville Medical Center, Inc., is a teaching hospital
5768 affiliated with the University of Florida Board of Trustees,
5769 located on the Jacksonville Campus of the University of Florida.
5770 Shands Jacksonville Medical Center, Inc., and Shands
5771 Jacksonville Healthcare, Inc., may, in support of the health

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5772 affairs mission of the University of Florida Board of Trustees
5773 and with its prior approval, create for-profit or not-for-profit
5774 corporate subsidiaries and affiliates, or both.

5775 (a) The University of Florida Board of Trustees, which may
5776 act through the President of the University of Florida or his or
5777 her designee, has the right to control Shands Jacksonville
5778 Medical Center, Inc., and Shands Jacksonville Healthcare, Inc.
5779 Shands Jacksonville Medical Center, Inc., Shands Jacksonville
5780 Healthcare, Inc., and any not-for-profit subsidiary of Shands
5781 Jacksonville Medical Center, Inc., are conclusively deemed
5782 corporations primarily acting as instrumentalities of the state,
5783 pursuant to s. 768.28(2), for purposes of sovereign immunity.

5784 (b) The University of Florida Board of Trustees is
5785 authorized to provide to Shands Jacksonville Healthcare, Inc.,
5786 and its not-for-profit subsidiaries and affiliates and any
5787 successor corporation that acts in support of the board of
5788 trustees, comprehensive general liability coverage, including
5789 professional liability, from the self-insurance programs
5790 established pursuant to s. 1004.24.

5791 Section 78. Sections 409.9121, 409.919, and 624.915,
5792 Florida Statutes, are repealed.

5793 Section 79. Section 409.942, Florida Statutes, is
5794 transferred and renumbered as section 414.29, Florida Statutes.

5795 Section 80. Paragraph (a) of subsection (1) of section
5796 443.111, Florida Statutes, is amended to read:

5797 443.111 Payment of benefits.—

5798 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
5799 in accordance with rules adopted by the Agency for Workforce
5800 Innovation, subject to the following requirements:

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5801 (a) Benefits are payable by mail or electronically.
5802 Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a
5803 system for the payment of benefits by electronic funds transfer,
5804 including, but not limited to, debit cards, electronic payment
5805 cards, or any other means of electronic payment that the agency
5806 deems to be commercially viable or cost-effective. Commodities
5807 or services related to the development of such a system shall be
5808 procured by competitive solicitation, unless they are purchased
5809 from a state term contract pursuant to s. 287.056. The agency
5810 shall adopt rules necessary to administer the system.

5811 Section 81. Sections 409.944, 409.945, and 409.946, Florida
5812 Statutes, are transferred and renumbered as sections 163.464,
5813 163.465, and 163.466, Florida Statutes, respectively.

5814 Section 82. Sections 409.953 and 409.9531, Florida
5815 Statutes, are transferred and renumbered as sections 402.81 and
5816 402.82, Florida Statutes, respectively.

5817 Section 83. The Agency for Health Care administration shall
5818 submit an reorganizational plan to the Governor, the Speaker of
5819 the House of Representatives, and the President of the Senate by
5820 January 1, 2012, which converts the agency from a check-writing
5821 and fraud-chasing agency into a contract compliance and
5822 monitoring agency.

5823 Section 84. Effective December 1, 2011, if the Legislature
5824 has not received a letter from the Governor stating that the
5825 federal Centers for Medicare and Medicaid has approved the
5826 waivers necessary to implement the Medicaid managed care reforms
5827 contained in this act, the State of Florida shall withdraw from
5828 the Medicaid program effective December 31, 2011.

5829 Section 85. If any provision of this act or its application

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5830 to any person or circumstance is held invalid, the invalidity
5831 does not affect other provisions or applications of the act
5832 which can be given effect without the invalid provision or
5833 application, and to this end the provisions of this act are
5834 severable.

5835 Section 86. This act shall take effect upon becoming a law.

MEDICAID BILL

28-01190A-11

Section, Page and Line References

Section	Provisions	Page	Line
1	amending s. 216.262, F.S.; providing that limitations on an agency's total number of positions does not apply to certain positions in the Department of Health;	14	382
2	amending s. 393.063, F.S.; redefining the term "developmental disability" to include Down syndrome; defining the term "Down syndrome" as it relates to developmental disabilities;	15	418
3	amending s. 393.0661, F.S.; conforming provisions to changes made by the act;	15	433
4, 5	amending s. 408.7057, F.S.; requiring that the dispute resolution program include a hearing in specified circumstances; providing that the dispute resolution program established to resolve claims disputes between providers and health plans does not provide an independent right of recovery; requiring that the conclusions of law in the written recommendation of the resolution organization identify certain information; providing a directive to the Division of Statutory Revision;	16	458
6	amending s. 409.016, F.S.; conforming provisions to changes made by the act;	17	490
7, 8	transferring s. 409.16713, F.S.; providing for medical assistance for children in out-of-home care and adopted children; specifying how those services will be funded under certain circumstances; providing legislative intent; providing a directive to the Division of Statutory Revision;	18	562
9	transferring, renumbering, and amending s. 624.91, F.S.; decreasing the administrative cost and raising the minimum loss ratio for health plans; increasing compensation to the insurer or provider for dental contracts; requiring the Florida Healthy Kids Corporation to include use of the school breakfast and lunch application form in the corporation's plan for publicizing the program; conforming provisions to changes made by the act;	19	539
10, 11, 12, 13, 14, 15	amending ss. 409.813, 409.8132, 409.815, 409.818, 154.503, and 408.915, F.S.; conforming provisions to changes made by the act;	23	660
16, 17	amending s. 1006.06, F.S.; requiring school districts to collaborate with the Florida Kidcare program to use the application form for the school breakfast and lunch programs to provide information about the Florida Kidcare program and to authorize data on the application form be shared with state agencies and the Florida Healthy Kids Corporation and its agents; authorizing each school district the option to share the data electronically; requiring interagency agreements to ensure that the data exchanged is protected from unauthorized disclosure and is used only for enrollment in the Florida Kidcare program;	26	735
18	amending s. 409.901, F.S.; revising definitions relating to Medicaid;	27	763

Section	Provisions	Page	Line
19	amending s. 409.902, F.S.; revising provisions relating to the designation of the Agency for Health Care Administration as the state Medicaid agency; specifying that eligibility and state funds for medical services apply only to citizens and certain noncitizens; providing exceptions; providing a limitation on persons transferring assets in order to become eligible for Medicaid nursing facility services;	34	974
20	amending s. 409.9021, F.S.; revising provisions relating to conditions for Medicaid eligibility; increasing the number of years a Medicaid applicant forfeits entitlements to the Medicaid program if he or she has committed fraud; providing for the payment of monthly premiums by Medicaid recipients; providing exemptions to the premium requirement; requiring applicants to agree to participate in certain health programs; prohibiting a recipient who has access to employer-sponsored health care from obtaining services reimbursed through the Medicaid fee-for-service system; requiring the agency to develop a process to allow the Medicaid premium that would have been received to be used to pay employer premiums; requiring that the agency allow opt-out opportunities for certain recipients;	37	1059
21	transferring s. 409.9022, F.S.; specifying procedures to be implemented by a state agency if the Medicaid expenditures exceed appropriations;	39	1122
22	amending s. 409.903, F.S.; conforming provisions to changes made by the act; deleting obsolete provisions;	41	1177
23	amending s. 409.904, F.S.; conforming provisions to changes made by the act; renaming the “medically needy” program as the “Medicaid nonpoverty medical subsidy”; narrowing the subsidy to cover only certain services for a family, persons age 65 or older, or blind or disabled persons; revising the criteria for the agency’s assessment of need for private duty nursing services;	44	1269
24	amending s. 409.905, F.S.; conforming provisions to changes made by the act; requiring prior authorization for home health services;	48	1380
25	amending s. 409.906, F.S.; providing for a parental fee based on family income to be assessed against the parents of children with developmental disabilities served by home and community-based waivers; prohibiting the agency from paying for certain psychotropic medications prescribed for a child; conforming provisions to changes made by the act;	59	1696
26, 27	amending ss. 409.9062 and 409.907, F.S.; conforming provisions to changes made by the act;	71	2036
28	amending s. 409.908, F.S.; modifying the nursing home patient care per diem rate to include dental care and podiatric care; directing the agency to seek a waiver to treat a portion of the nursing home per diem as capital for self-insurance purposes; requiring primary physicians to be paid the Medicare fee-for-service rate by a certain date; deleting the requirement that the agency contract for transportation services with the community transportation system; authorizing qualified plans to contract for transportation services; deleting obsolete provisions; conforming provisions to changes made by the act;	72	2068

Section	Provisions	Page	Line
29	amending s. 409.9081, F.S.; revising copayments for physician visits; requiring the agency to seek a waiver to allow the increase of copayments for nonemergency services furnished in a hospital emergency department;	93	2679
30	amending s. 409.912, F.S.; requiring Medicaid-eligible children who have open child welfare cases who reside in AHCA area 10 to be enrolled in specified capitated managed care plans; expanding the number of children eligible to receive behavioral health care services through a specialty prepaid plan; repealing provisions relating to a provider lock-in program; eliminating obsolete provisions and updating provisions; conforming cross-references;	94	2705
31	amending s. 409.915, F.S.; conforming provisions to changes made by the act;	106	3048
32	transferring, renumbering, and amending s. 409.9301, F.S.; conforming provisions to changes made by the act;	106	3065
33, 34	amending s. 409.9126, F.S.; conforming a cross-reference; providing a directive to the Division of Statutory Revision;	107	3086
35	transferring s. 409.961, F.S.; providing for statutory construction of provisions relating to Medicaid managed care;	107	3099
36	transferring s. 409.962, F.S.; providing definitions;	108	3107
37	transferring s. 409.963, F.S.; establishing the Medicaid managed care program as the statewide, integrated managed care program for medical assistance and long-term care services; directing the agency to apply for and implement waivers; providing for public notice and comment; providing for a limited managed care program if waivers are not approved;	108	3132
38	transferring s. 409.964, F.S.; requiring all Medicaid recipients to be enrolled in Medicaid managed care; providing exemptions; prohibiting a recipient who has access to employer-sponsored health care from enrolling in Medicaid managed care; requiring the agency to develop a process to allow the Medicaid premium that would have been received to be used to pay employer premiums; requiring that the agency allow opt-out opportunities for certain recipients; providing for voluntary enrollment;	111	3212
39	transferring s. 409.965, F.S.; providing requirements for qualified plans that provide services in the Medicaid managed care program; requiring the agency to issue an invitation to negotiate; requiring the agency to compile and publish certain information; establishing regions for separate procurement of plans; establishing selection criteria for plan selection; limiting the number of plans in a region; authorizing the agency to conduct negotiations if funding is insufficient; providing that the Children's Medical Service Network is a qualified plan;	113	3274

Section	Provisions	Page	Line
40	transferring s. 409.966, F.S.; providing managed care plan contract requirements; establishing contract terms; providing for annual rate setting; providing for contract extension under certain circumstances; establishing access requirements; requiring the agency to establishing performance standards for plans; providing for program integrity; requiring plans to provide encounter data; providing penalties for failure to submit data; requiring plans to accept electronic claims; providing for prompt payment; providing for payments to noncontract emergency providers; requiring a surety bond; requiring plans to establish a grievance resolution process; requiring plan solvency; requiring guaranteed savings; providing costs and penalties for early termination of contracts or reduction in enrollment levels; requiring the agency to terminate qualified plans for noncompliance under certain circumstances;	119	3430
41	transferring s. 409.967, F.S.; providing for managed care plan accountability; establishing a medical loss ratio; requiring that a plan pay back to the agency a specified amount in specified circumstances; authorizing plans to limit providers in networks; mandating that certain providers be offered contracts during the first year; authorizing plans to exclude certain providers in certain circumstances; requiring plans to monitor the quality and performance history of providers; requiring plans to hold primary care physicians responsible for certain activities; requiring plans to offer certain programs and procedures; requiring plans to pay primary care providers the same rate as Medicare by a certain date; providing for conflict resolution between plans and providers;	125	3618
42	transferring s. 409.968, F.S.; providing for managed care plan payments on a per-member, per-month basis; requiring the agency to establish a methodology to ensure the availability of certain types of payments to specified providers; requiring the development of rate cells; requiring that the amount paid to the plans for supplemental payments or enhanced rates be reconciled to the amount required to pay providers; requiring that plans make certain payments to providers within a certain time;	130	3770
43	transferring s. 409.969, F.S.; authorizing Medicaid recipients to select any plan within a region; providing for automatic enrollment of recipients by the agency; providing criteria for automatic enrollment; authorizing disenrollment under certain circumstances; providing for a grievance process; defining the term “good cause” for purposes of disenrollment; requiring recipients to stay in plans for a specified time; providing for reenrollment of recipients who move out of a region;	132	3811
44	transferring s. 409.970, F.S.; requiring the agency to maintain an encounter data system; providing requirements for prepaid plans to submit data in a certain format; requiring the agency to analyze the data; requiring the agency to test the data for certain purposes by a certain date;	135	3897
45	transferring s. 409.971, F.S.; providing for managed care medical assistance; providing deadlines for beginning and finalizing implementation;	136	3832

Section	Provisions	Page	Line
46	transferring s. 409.972, F.S.; establishing minimum services for the managed medical assistance; providing for optional services; authorizing plans to customize benefit packages;	136	3943
47	transferring s. 409.973, F.S.; providing for managed long-term care; providing deadlines for beginning and finalizing implementation; providing duties for the Department of Elderly Affairs relating to the program;	138	3997
48	transferring s. 409.974, F.S.; providing recipient eligibility requirements for managed long-term care; listing programs for which certain recipients are eligible; specifying that an entitlement to home and community-based services is not created;	139	4022
49	transferring s. 409.975, F.S.; establishing minimum services for managed long-term care;	140	4054
50	transferring s. 409.976, F.S.; providing criteria for the selection of plans to provide managed long-term care;	141	4072
51	transferring s. 409.977, F.S.; providing for managed long-term care plan accountability; requiring the agency to establish and plans to comply with standards for specified providers;	143	4134
52	transferring s. 409.978, F.S.; requiring that the agency operate the Comprehensive Assessment and Review for Long-Term Care Services program through an interagency agreement with the Department of Elderly Affairs; providing duties of the program; requiring the program to assign plan enrollees to a level of care; providing for the evaluation of dually eligible nursing home residents;	144	4151
53, 54, 55, 56, 57	transferring, renumbering, and amending ss. 409.91207, 409.91211, 409.9122, F.S.; conforming provisions to changes made by the act; updating provisions and deleting obsolete provisions; transferring and renumbering ss. 409.9123 and 409.9124, F.S.;	145	4201
58	amending s. 430.04, F.S.; eliminating outdated provisions; requiring the Department of Elderly Affairs to develop a transition plan for specified elders and disabled adults receiving long-term care Medicaid services if qualified plans become available;	150	4332
59	amending s. 430.2053, F.S.; eliminating outdated provisions; providing additional duties of aging resource centers; providing an additional exception to direct services that may not be provided by an aging resource center; providing for the cessation of specified payments by the department as qualified plans become available; eliminating provisions requiring reports;	151	4356
60	amending s. 39.407, F.S.; requiring a motion by the Department of Children and Family Services to provide psychotropic medication to a child 10 years of age or younger to include a review by a child psychiatrist; providing that a court may not authorize the administration of such medication absent a finding of compelling state interest based on the review;	162	4677
61	amending s. 400.023, F.S.; requiring the trial judge to conduct an evidentiary hearing to determine the sufficiency of evidence for claims against certain persons relating to a nursing home; limiting noneconomic damages in a wrongful death action against the nursing home;	166	4799

Section	Provisions	Page	Line
62	amending s. 400.0237, F.S.; revising provisions relating to punitive damages against a nursing home; authorizing a defendant to proffer admissible evidence to refute a claimant's proffer of evidence for punitive damages; requiring the trial judge to conduct an evidentiary hearing and the plaintiff to demonstrate that a reasonable basis exists for the recovery of punitive damages; prohibiting discovery of the defendant's financial worth until the judge approves the pleading on punitive damages; revising definitions;	170	4908
63	amending s. 409.1671, F.S.; modifying the amount and limits of general liability coverage, automobile coverage, and tort coverage that must be carried by eligible community lead agency providers and their subcontractors; providing that the Department of Children and Family Services is not liable for the acts or omissions of such lead agencies and that the agencies may not be required to indemnify the department;	172	4970
64, 66	transferring ss. 458.3167 and 459.0078, F.S.; providing for an expert witness certificate for allopathic and osteopathic physicians licensed in other states or Canada which authorizes such physicians to provide expert medical opinions in this state; providing application requirements and timeframes for approval or denial by the Board of Medicine and Board of Osteopathic Medicine, respectively; requiring the boards to adopt rules and set fees; providing for expiration of a certificate;	178	5153
65, 67	amending ss. 458.331 and 459.015, F.S.; providing grounds for disciplinary action for providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of medicine and of osteopathic medicine, respectively; providing for construction with respect to the doctrine of incorporation by reference;	179	5188
68	amending s. 766.102, F.S.; providing that a physician who is an expert witness in a medical malpractice presuit action must meet certain requirements;	182	5256
69	amending s. 766.104, F.S.; requiring a good faith demonstration in a medical malpractice case that there has been a breach of the standard of care;	182	5268
70	amending s. 766.106, F.S.; clarifying that a physician acting as an expert witness is subject to disciplinary actions;	183	5303
71	amending s. 766.1115, F.S.; conforming provisions to changes made by the act;	184	5321
72	transferring s. 766.1183, F.S.; defining terms; providing for the recovery of civil damages by Medicaid recipients according to a modified standard of care; providing for recovery of certain excess judgments by act of the Legislature; requiring the Department of Children and Family Services to provide notice to program applicants;	185	5337
73	transferring s. 766.1184, F.S.; defining terms; providing for the recovery of civil damages by certain recipients of primary care services at primary care clinics receiving specified low-income pool funds according to a modified standard of care; providing for recovery of certain excess judgments by act of the Legislature; providing requirements of health care providers receiving such funds in order for the liability provisions to apply; requiring notice to low-income pool recipients;	186	5386

Section	Provisions	Page	Line
74	amending s. 766.203, F.S.; requiring the presuit investigations conducted by the claimant and the prospective defendant in a medical malpractice action to provide grounds for a breach of the standard of care;	189	5468
75, 76	amending s. 768.28, F.S.; revising a definition; providing that colleges and universities that own or operate an accredited medical school and their employees and agents providing patient services in a public teaching hospital pursuant to an affiliation agreement or contract with the teaching hospital are considered agents of the hospital for the purposes of the applicability of sovereign immunity; providing definitions; requiring patients of such hospitals to be provided with notice of their remedies under sovereign immunity; providing legislative findings and intent with respect to including colleges and universities and their employees and agents under sovereign immunity; providing a statement of public necessity;	190	5482
77	amending s. 1004.41, F.S.; clarifying provisions relating to references to the corporation known as Shands Teaching Hospital and Clinics, Inc.; clarifying provisions regarding the purpose of the corporation; authorizing the corporation to create corporate subsidiaries and affiliates; providing that Shands Teaching Hospital and Clinics, Inc., Shands Jacksonville Medical Center, Inc., Shands Jacksonville Healthcare, Inc., and any not-for-profit subsidiary of such entities are instrumentalities of the state for purposes of sovereign immunity;	195	5645
78	repealing s. 409.9121, F.S., relating to legislative intent concerning managed care; repealing s. 409.919, F.S., relating to rule authority; repealing s. 624.915, F.S., relating to the Florida Healthy Kids Corporation operating fund;	200	5791
79, 81, 82	renumbering and transferring ss. 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, F.S., as ss. 414.29, 163.464, 163.465, 163.466, 402.81, and 402.82, F.S., respectively;	200	5793
80	amending s. 443.111, F.S.; conforming a cross-reference;	200	5795
83	directing the Agency for Health Care Administration to submit a reorganization plan to the Legislature;	201	5817
84	providing for the state's withdrawal from the Medicaid program under certain circumstances;	201	5823
85	providing for severability;	201	5829
86	providing an effective date.	202	5835

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Section 1: Authorized Dept. of Health Positions

Amends s. 216.262, F.S.

Exempts FTEs in the Dept. of Health that are funded by the County Health Dept. Trust Fund from the requirement that the total number of authorized positions at a state agency may not exceed the total provided in the GAA and allows CHDs the flexibility to establish and delete positions without legislative approval.

Section 2: Down Syndrome

Amends s. 393.063, F.S.

Amends definition of “developmental disability” to specifically include “Down syndrome.” Provides definition of “Down syndrome.”

- Intended effect is to provide services to any person who presents with a diagnosis of Down, i.e., presence of an extra chromosome 21, prior to age 18 without requiring an IQ test.
- Expected to expand Medicaid eligibility, but by what amount is unknown at this time.

Section 3: Home and Community-based Services Delivery System

Amends s. 393.0661, F.S.

Directs the Agency for Persons with Disabilities to impose and collect a fee upon approval from the federal CMS. The fee in question is created later in the bill (Section 25) and is a sliding-scale parental fee to be assessed on all parents of children under age 18 being served by a HCB waiver with an adjusted household income over 100 percent of FPL

Section 4: Claim Dispute Resolution Program

Amends s. 408.7057, F.S.

Amends the existing statewide provider and health plan claim dispute resolution program. Establishes that this section creates a procedure for dispute resolution and not an independent right of recovery. The conclusions of law contained in the written recommendation of the resolution organization must identify the provisions of law or contract which, under the peculiar facts and circumstances of the case, entitle the provider or health plan to the amount awarded, if any.

Section 5: Part I of Chapter 409

Requests the Division of Statutory Revision to designate ss. 409.016 through 409.803, F.S., as part I of chapter 409, F.S., entitled “SOCIAL AND ECONOMIC ASSISTANCE.”

Section 6: Definitions in Current Law (technical)

Amends s. 409.016, F.S., to make some minor clarifications to definitions.

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Section 7: Medical Care for Foster Kids

Creates s. 409.16713, F.S., relating to medical services for children in out-of-home care and adopted children.

Provides that those children and youth currently eligible for Medicaid remain so. Provides that if the federal government does not provide Florida with funds to support its Medicaid program, then those children and youth are eligible for medical services under the Managed Care Program and that medical coverage is to be procured by the CBC with funds appropriated for that purpose. Provides legislative intent.

Intended to ensure that Florida provides those children and youth with medical services necessary to comply with TANF and IV-E requirements, in order to continue receiving TANF and IV-E foster care and adoptions funding.

Section 8: Part II of Chapter 409

Requests the Division of Statutory Revision to designate ss. 409.810 through 409.821, Florida Statutes, as part II of chapter 409, Florida Statutes, and entitled "KIDCARE."

Section 9: Kidcare

Transfers s. 624.91, F.S., relating to the Fla Healthy Kids Corporation, to s. 409.8115, F.S., and makes technical changes and the following substantive changes:

- Changes the minimum MLR for health plans in the Healthy Kids program from 85 percent to 90 percent.
- Requires the Florida Healthy Kids Corporation, in the development and implementation of a plan for publicizing the Florida Kidcare program, to include the use of application forms for school lunch and breakfast programs (Senator Sobel language).

Section 10: FHKC (technical)

Amends s. 409.813, F.S., to make some technical changes to Kidcare statutes.

Section 11: Kidcare (technical)

Amends s. 409.8132, F.S., to make some technical changes to Kidcare statutes.

Section 12: Kidcare (technical)

Amends s. 409.815, F.S., to make some technical changes to Kidcare statutes.

Section 13: Kidcare (technical)

Amends s. 409.818, F.S., to make a technical change to Kidcare statutes.

Section 14: Kidcare (technical)

Amends s. 154.503, F.S., to make a technical change for Kidcare.

Section 15: Kidcare (technical)

Amends s. 408.915, F.S., to make a technical change for Kidcare.

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Section 16: Kidcare and School Lunch/Breakfast Programs

Amends s. 1006.06, F.S.

Requires that school districts must provide application information about Kidcare or an application for Kidcare to students at the beginning of each school year, and modify the school district's application form for school breakfast and lunch programs to incorporate a provision that permits the school district to share data from the application form with the Florida Healthy Kids Corporation state agencies that administer Kidcare, unless the child's parent or guardian opts out of the provision. (Senator Sobel language)

Section 17: Part III of Chapter 409

Requests the Division of Statutory Revision to designate ss 409.901 through 409.9205, Florida Statutes, as part III of chapter 409, Florida Statutes, and entitled "MEDICAID."

Section 18: Medicaid Definitions in Current Law (technical)

Amends s. 409.901, F.S., to make some technical and clarifying changes to Medicaid definitions.

Section 19: Medicaid Eligibility and Loopholes

Amends s. 409.902, F.S., regarding Medicaid eligibility and rules.

- Medicaid eligibility is restricted to U.S. citizens and lawfully admitted non-citizens. Citizenship or immigration status must be verified. State funds may not be used for individuals who do not qualify under these standards unless the services are necessary for treating an emergency medical condition or for pregnant women.
- Includes new language to provide criteria for DCF to use when evaluating personal care contracts. Intended to address concerns about Medicaid estate planning techniques. Provides DCF rulemaking authority.

Section 20: Eligibility and Requirement for Medicaid Premiums

Amends s. 409.9021, F.S., relating to conditions for Medicaid eligibility.

Additional conditions for Medicaid eligibility are created, subject to federal regulation and approval:

- An applicant must consent to forfeit all entitlement to Medicaid goods or services for 10 years if found to have committed Medicaid fraud.
- An applicant must consent to the release of her or his medical records to the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs.
- A recipient may be required to pay a \$10 monthly premium for Medicaid coverage subject to the approval of a federal waiver, except for SSI recipients in institutional care.

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- An applicant must consent to participate, in good faith, in a medically-approved smoking cessation program if the applicant smokes, a medically-directed weight loss program if the applicant is or becomes morbidly obese, and a medically-approved alcohol or substance abuse recovery program if the applicant is or becomes diagnosed as a substance abuser.

The language authorizes the agency to adopt rules providing for premium collection, advance notice of cancellation, and waiting periods for reinstatement of coverage upon cancellation for nonpayment of premiums. The agency is also directed to seek federal waiver authority to implement the provisions designed to assist recipients mitigate lifestyle choices and avoid behaviors associated with high-cost medical services.

Requires that a person eligible for Medicaid and who has access to coverage through an employer-sponsored health plan may not receive Medicaid services reimbursed under Medicaid but may use Medicaid financial assistance to pay the cost of premiums for the employer-sponsored coverage for himself/herself and his/her Medicaid-eligible family members. Also, a Medicaid recipient who has access to other insurance coverage created by state or federal law may opt-out of Medicaid-provided services and use Medicaid financial assistance to pay the cost of premiums for the recipient and his/her Medicaid-eligible family members.

Allows for Medicaid financial assistance to pay premiums in either of the above cases, not to exceed the capitation that would have been paid to a qualified Medicaid health plan for such coverage under the new managed care system created later in the bill.

Section 21: Limitations on Medicaid Expenditures

Creates s. 409.9022, F.S., relating to limitations on Medicaid expenditures.

Prohibits any state agency that administers a Medicaid program or waiver from expending funds during any fiscal year in excess of the amount appropriated in the GAA. If an agency determines that it will spend more than appropriated, it is required to notify the Social Services Estimating Conference and the conference is required to meet to determine if a Medicaid deficit will occur. Upon a determination by the conference that a Medicaid deficit will occur, an agency is required to take action during the fiscal year to remedy the deficit, including submitting a budget amendment to the LBC to reduce Medicaid spending in that fiscal year, or submitting any other type of budget amendment authorized in Chapter 216, F.S.

Section 22: Medicaid (technical)

Amends s. 409.903, F.S., to make some technical and clarifying changes.

Section 23: Medicaid Nonpoverty Medical Subsidy Program

Amends s. 409.904, F.S.

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Renames the Medically Needy program as the Medicaid Nonpoverty Medical Subsidy, or MNMS, program, and limits coverage to physician services only. Also makes some technical changes.

Section 24: Mandatory Medicaid Services

Amends s. 409.905, F.S.

- Requires the agency to prior-authorize home health services (by changing “may” to “shall”).
- Requires an assessment of need for private-duty nursing services to specifically include medical necessity for such services instead of other more cost-effective services.
- Makes some technical and clarifying changes.

Section 25: Medicaid Optional Services

Amends s. 409.906, F.S., relating to optional Medicaid services.

- Creates a sliding-scale parental fee to be assessed on all parents of children under age 18 being served by a HCB waiver with an adjusted household income over 100 percent of FPL.
- Prohibits AHCA from paying for psychotropic medications prescribed for a child younger than the age approved by the FDA.
- Makes some technical and clarifying changes.

Section 26: Medicaid Lung Transplants (technical)

Amends s. 409.9062, F.S., relating to lung transplant services, to make some technical and clarifying changes.

Section 27: Medicaid Provider Agreements (conforming)

Amends s. 409.907, F.S., relating to Medicaid provider agreements, to conform to legal liability provisions created in s. 766.1183 later in the bill.

Section 28: Medicaid Provider Reimbursements

Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.

- Requires that Medicaid fee-for-services payments to primary care physicians for primary care services may not be less than 100 percent of the Medicare payment rate for such services, effective January 1, 2013.
- Removes the requirement in existing law that AHCA must purchase transportation services via the community coordinated transportation system under the umbrella of the Commission for the Transportation Disadvantaged. Further requires AHCA to either competitively procure transportation services or secure federal waiver authority necessary to draw down the highest federal match available for transportation services.

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- Requires Medicaid qualified plans to provide access to covered Medical services and states that plans are not required to purchase transportation services via the community coordinated transportation system under the umbrella of the Commission for the Transportation Disadvantaged.
- Makes some technical and clarifying changes.

Section 29: Medicaid Copayments

Amends s. 409.9081, F.S., relating to copayments.

Requires that Medicaid recipients must pay copayments at the time of service, subject to federal waiver authority. Creates a \$3 copayment for visiting a specialty physician. Directs AHCA to seek a waiver of the federal requirement that cost sharing amounts for non-emergency services and care furnished in a hospital emergency department be nominal. Upon waiver approval, each Medicaid recipient must pay a \$100 copayment for non-emergency services and care provided in a hospital emergency department (instead of \$15 under current law).

Section 30: Amend Certain Provisions of Current Medicaid Law

Amends s. 409.912, F.S., relating to cost-effective purchasing of health care. Most notably:

- Paragraph (b) of subsection (4) relating to managed behavioral health care is amended to require that 90 percent (as opposed to 80 percent in current law) of the capitation paid to behavioral managed care plans must be spent on behavioral health services and that if a plan spends less, it must return the difference to AHCA.
- Paragraph (b) of subsection (4) is also amended to enroll foster children who reside in Highlands, Hardee, and Polk counties into the statewide behavioral managed care system for such children. Foster kids in those counties are currently excluded, as are foster kids in Escambia, Okaloosa, Santa Rosa, Walton, and Manatee counties. Foster kids in the latter counties would remain excluded.

Section 31: County Contributions (technical)

Amends s. 409.915, F.S., relating to county contributions to Medicaid, to make a technical change.

Section 32: Technical

Transfers and renumbers s. 409.9301, F.S. as section 409.9067 and amends subsections (1) and (2) to make some technical changes.

Section 33: Technical

Amends s. 409.9126, F.S., relating to children with special health care needs, to make a technical change.

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Section 34: Part IV of Chapter 409

Requests the Division of Statutory Revision to create part IV of chapter 409, F.S., consisting of sections 409.961 through 409.978, entitled “MEDICAID MANAGED CARE.”

Section 35: Statutory Conflicts

Creates s. 409.961, F.S.

Expresses legislative intent that if any conflict exists between ss. 409.961-409.978 and other parts or sections of ch. 409, the provisions of ss. 409.961-409.978 control, and those sections apply only to the Medicaid managed care program.

Section 36: Definitions

Creates s. 409.962, F.S., relating to definitions for pt. IV of ch. 409.

Section 37:

New Managed Care Program; Superwaiver Authority vs. State-only Program

Creates s. 409.963, F.S.

Establishes the new Medicaid managed care program. Directs AHCA to submit waiver and state plan amendment requests by August 1, 2011, as needed to implement the program. At a minimum, the requests must include a waiver to permit home and community-based services to be preferred before nursing home services and a waiver to require dual-eligibles to participate in the program. Also, the waiver is supposed to allow Florida to limit enrollment in managed LTC (in order to combat the “woodwork” effect).

Requires AHCA to initiate procurement processes as soon as practicable and no later than July 1, 2011, in anticipation of federal waiver authority. Requires AHCA to seek waiver approval by December 1, 2011, in order to begin implementation on December 31, 2011. Requires public notice and opportunity for public comment.

Requires AHCA to begin implementing on December 31, 2011. If necessary waivers are not timely received, directs AHCA to notify CMS of the state’s implementation of the program and request the federal agency to continue providing federal funds, as provided under the current Medicaid program, to be used for Florida’s new program.

- If CMS refuses to continue providing federal funds, the managed care program will be implemented to the extent state funds are available.
- If implemented as a state-only-funded program, priority will be given to providing
 - Nursing home services to persons eligible for nursing home care
 - Medical services for persons served by APD
 - Medical services to pregnant women

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- Physician and hospital services to persons who are eligible for Medicaid
- Healthy Start waiver services
- Medical services provided to persons in nursing home diversion
- Medical services provided to persons in ICF/DDs
- Medical care for children in the child welfare system, whose medical care shall be provided in accordance with s. 409.16713 as authorized by the GAA.
- If implemented as a state-only-funded program, all provisions related to eligibility standards of the state and federal Medicaid program remain in effect except as specifically provided under the managed care program.
- If implemented as a state-only-funded program, provider agreements and contracts necessary to provide for the preferred services listed above will remain in effect.

Section 38: Mandatory, Excluded and Voluntary Populations; Opt-out
Creates s. 409.964, F.S.

Requires all Medicaid recipients to receive covered services through the Medicaid managed care program unless excluded. Exclusions include:

- a. Women eligible only for family planning services
- b. Women eligible only for breast and cervical cancer services
- c. Persons with a developmental disability
- d. Persons eligible for the Medicaid Nonpoverty Medical Subsidy program
- e. Persons receiving emergency Medicaid services for aliens
- f. Persons residing in a nursing home facility or are considered a resident under the nursing home's bed-hold policy on or before July 1, 2011.
- g. Persons who are eligible for and receiving prescribed pediatric extended care.
- h. Persons eligible for Medicaid who have access to employer-sponsored health coverage. Medicaid financial assistance is available to pay premiums for such coverage for the eligible and his/her eligible family members. The amount of financial assistance may not exceed the capitations that would be paid to a qualified plan for the recipient and his/her eligible family members. A person is deemed to have access to employer-sponsored coverage only if the financial assistance available is sufficient to pay premiums. Also allows persons with access to other coverage created by state or federal law to opt-out of Medicaid coverage under the same premium-assistance conditions as for employer-sponsored coverage.

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Provides for voluntary enrollment for those who are exempt from mandatory enrollment, including:

- a. Recipients residing in residential commitment facilities operated through DJJ, group care facilities operated by DCF, and treatment facilities funded through the Substance Abuse and Mental Health program of DCF
- b. Persons eligible for refugee assistance

Provides that Medicaid recipients who are exempt from mandatory participation under this section and who do not choose to enroll in the Medicaid managed care program shall be served through Medicaid fee-for-service.

Section 39: Regions and Procurement

Creates s. 409.965, F.S.

- Establishes 19 regions in which qualified plans will provide Medicaid services.
- Provides that AHCA will conduct a competitive bid process and that separate ITNs will be issued for the managed medical assistance program and the managed long-term care program. Establishes selection criteria and process.
- Establishes the CMS network as a qualified plan under statewide contract that is not subject to the procurement requirements.
- Prohibits AHCA from selecting more than one plan per 20,000 Medicaid recipients residing in each region who are subject to mandatory enrollment, with a maximum of 10 plans per region.
- Requires AHCA to publish a databook containing information plans will need to formulate an ITN response.
- Provides for negotiation with qualified plans based on the adequacy of GAA funding.

Section 40: Contract Standards

Creates s. 409.966, F.S.

Establishes standards for managed care contracts, including 5-year durations, non-renewal of contracts, a primary care physician for each member, prompt pay, required rate of pay for non-contracted providers of emergency services, plan network adequacy, encounter data reporting, quality and performance standards, fraud prevention, grievance resolution, penalties, performance bonds, solvency standards, guaranteed savings, and penalties.

Section 41: Medical Loss Ratios and Plan Accountability

Creates s. 409.967, F.S.

- Establishes minimum medical loss ratios for plans similar to the MLR standards of the Healthy Kids program. Requires AHCA to adopt rules for calculating and reporting MLRs. Applies the minimum MLR requirement only to the medical assistance component, not the LTC component.

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- Establishes requirements for plans to include providers in their networks. During first year after the initial procurement in a region, plans must offer contracts to FQHCs and (for LTC plans) nursing homes and certain aging network service providers in the region.
- Requires plans and providers to negotiate in good faith. Establishes a procedure for dealing with provider contracting impasses in areas containing no capitated plans prior to July 1, 2011. Requires AHCA to examine the negotiation process to determine good faith, under certain parameters, and based on the findings, a provider may be deemed part of a plan's network for the purpose of network adequacy and the plan must pay the provider rates determined by AHCA to be the average of rates for corresponding services paid in the region and similar counties under similar circumstances.
- Allows AHCA to continue calculating fee-for-service rates for Medicaid hospital inpatient and outpatient services, but specifies that these rates may not be the basis for contract negotiations between plans and hospitals.
- Requires plans to monitor the quality and performance of network providers based on metrics established by AHCA.
- Requires qualified plans to compensate primary care physicians with payments equivalent to or greater than the Medicare rate for primary care services no later than January 1, 2013.
- Requires non-LTC plans to establish specific programs and procedures to improve pregnancy outcomes and infant health.
- Requires non-LTC plans to achieve an 80% EPSDT rate for recipients continuously enrolled for at least 8 months.
- Requires that unresolved disputes between a qualified plan and a provider shall proceed in accordance with s. 408.7057, which is the existing statewide provider and health plan claim dispute resolution program.

Section 42: Plan Payment and IGTs

Creates s. 409.968, F.S.

Provides that plans will be paid per-member, per-month payments based on an assessment of each member's acuity level and that payment for LTC plans will be combined with rates for medical assistance plans. Requires AHCA to develop a methodology that ensures the availability of IGTs.

Section 43: Enrollment, Disenrollment, and Grievances

Creates s. 409.969, F.S.

Provides that recipients may choose from plans available in their region of residence. Recipients who have not chosen within 30 days of becoming eligible will be automatically assigned to a plan. Provides guidelines for auto-assignment based on certain criteria, including family continuity, adherence to quality

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standards, network capacity, prior enrollment, and geographic accessibility of providers. Requires enrollment for 12-month period, except for a 90-day window at the outset of enrollment and “good cause” as determined by AHCA.

Section 44: Encounter Data

Creates s. 409.970, F.S.

Requires AHCA to maintain and operate the Medicaid Encounter Data System. Provides guidelines for data reporting, validation, and analysis. Requires qualified plans to submit encounter data according to deadlines established by AHCA.

Section 45: Managed Care Medical Assistance

Creates s. 409.971, F.S.

Requires AHCA to begin implementing the new managed care medical assistance component as of December 31, 2011 and finish implementing the component in all regions no later than December 31, 2012. Applies ss. 409.961-409.970 to the medical assistance component.

Section 46: Medical Assistance Services

Creates s. 409.972, F.S.

Establishes minimum services that plans must provide in the medical assistance component. Allows for additional services as specified in the GAA. Allows plans to customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services, subject to standards of sufficiency and actuarial equivalence. Requires services provided to be medically necessary. Authorizes the agency to adjust fees, reimbursement rates, length of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the GAA or s. 409.9022, F.S.

Section 47: Managed Long-term Care

Creates s. 409.973, F.S.

Establishes the managed long-term care program. Requires the agency to begin implementing the managed long-term care program by March 31, 2012, with full implementation in all regions by March 31, 2013. Applies the provisions of ss. 409.961-409.970 to the managed long-term care program. Requires AHCA to make payments for long-term care, including home and community-based services, using a capitated managed care model. Requires DOEA to assist the agency develop specifications for ITNs and the model contract, determine clinical eligibility for enrollment in managed long-term care plans, monitor plan performance and measure quality of service delivery, assist clients and families to address complaints with the plans, facilitate working relationships between plans and providers serving elders and disabled adults, and perform other functions specified in a memorandum of agreement.

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Section 48: LTC Eligibility

Creates s. 409.974, F.S.

Requires Medicaid recipients to receive covered long-term care services through the managed long-term care program unless excluded pursuant to s. 409.964. Recipients who meet all of the following criteria may participate in the managed long-term care program. Recipients must be:

- Sixty-five years of age or older or eligible for Medicaid by reason of a disability
- Determined by the CARES Program to meet the requirements for nursing facility care

Allows recipients already residing in a nursing home or enrolled in certain LTC waiver programs to remain eligible for those programs. Specifies that this part does not create an entitlement for any home and community based services provided under the program.

Section 49: LTC Services

Creates s. 409.975, F.S.

Establishes minimum benefits that managed LTC plans must provide, including all services provided by medical assistance plans, plus nursing facility services and home and community-based services, including but not limited to ALF services. Requires services provided to be medically necessary. Authorizes the agency to adjust fees, reimbursement rates, length of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the GAA, ch. 216, or s. 409.9022, F.S

Section 50: LTC Qualified Plans

Creates s. 409.976, F.S.

Adds the following plans to the list of qualified plans for LTC coverage: Medicare Advantage PPOs, Medicare Advantage PSOs, and Medicare Advantage special needs plans. Specifies that the PACE program is a qualified plan and is not subject to procurement requirements. Requires AHCA to issue an ITN by November 14, 2011. Establishes selection criteria and process.

Section 51: LTC Provider Networks

Creates s. 409.977, F.S.

Establishes requirements for LTC plans for including providers in their networks, in addition to the requirements for non-LTC plans.

Section 52: LTC Level of Care

Creates s. 409.978, F.S.

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Provides for an assessment of an enrollee's level of care by the CARES program.

Section 53: Medical Home Pilot (technical)

Transfers and renumbers s. 409.91207, F.S., relating to medical home pilot program, as s. 409.985.

Section 54: Medicaid Reform Pilot (technical)

Transfers and renumbers s. 409.91211, F.S., relating to the existing Medicaid Reform pilot program, as s. 409.986, F.S.

Section 55: Technical

Transfers and renumbers s. 409.9122, F.S., relating to managed care mandatory enrollment, to s. 409.987. Performs clean-up duty on the language within the statute.

Section 56: Technical

Transfers and renumbers s. 409.9123, F.S., relating to quality of care reporting, to s. 409.988.

Section 57: Technical

Transfers and renumbers s. 409.9124, F.S., relating to managed care reimbursement, to s. 409.989.

Section 58: LTC Waiver Transition

Amends s. 430.04, F.S.

Requires DOEA to transition persons from existing waivers to qualified managed care plans as they become available.

Section 59: Aging Resource Centers

Amends s. 430.2053, F.S.

Deletes obsolete language. Provides additional duties of Aging Resource Centers (ARCs):

- 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 qualified plans become available.
- Provide enrollment and coverage information for the Medicaid long-term care managed care program as qualified plans become available.
- Assist Medicaid recipients enrolled in the Medicaid long-term care managed care program with informally resolving grievances with a managed care network and in accessing the managed care network's formal grievance process as qualified plans become available.

Section 60: Psychotropic Drugs for Children in Foster Care

Amends s. 39.407, F.S.

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- Provides that for any child under the age of 11 in an out-of-home placement, any administration of a psychotropic medication must be reviewed by a child psychiatrist;
- Specifies criteria to be included in the review and requires that the results of the review be provided to the child and a parent or legal guardian before consent is given; and
- Provides that absent a compelling governmental interest, psychotropic medication may not be court-authorized for any child under the age of 11 in an out-of-home placement.

Sections 61 and 62: Nursing Home Civil Liability

Amend ss. 400.023 and 400.0237, F.S., respectively.

Revises the requirements for suing an officer or director of a nursing home or its management company for alleged negligence or a violation of rights enumerated in regulatory provisions applicable to nursing homes. The requirements for suing an officer, director, or owner of a nursing home for negligence or a violation of rights are modified to require an evidentiary hearing. The claimant must provide sufficient evidence for a court to determine that a reasonable basis exists for a finding that the nursing home's officer or other principal has breached, failed to perform, or acted outside the scope of the principal's duties. Such breach or failure must be the legal cause of actual loss, injury, death, or damage to the nursing home resident.

In wrongful death actions brought against a nursing home, the noneconomic damages may not exceed \$250,000, regardless of the number of claimants.

A hearing is required for the evaluation of evidence proffered by all parties for a judge's consideration of a punitive damages claim against a nursing home. In the hearing, the plaintiff must demonstrate that a reasonable basis exists for the recovery of punitive damages prior to any discovery of the nursing home's financial worth. The circumstances for which a nursing home is liable for punitive damages are modified to require the trier of fact as a prerequisite to find that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct or conduct amounting to gross negligence that contributed to the loss, damages, or injury suffered by the claimant.

The requirements for the recovery of punitive damages from a nursing home are revised. The defendant may proffer admissible evidence to refute the claimant's proffer of evidence to recover punitive damages. The trial judge must conduct an evidentiary hearing and weigh the admissible evidence proffered by the parties to ensure that a reasonable basis exists for the punitive damages claim by clear and convincing evidence.

In a situation where a nursing home employer is vicariously liable for the conduct of employees, officers, directors, managers or others, additional requirements are imposed on punitive damage claims. A defendant may be liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds

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that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct or engaged in conduct that constituted gross negligence. Punitive damages may not be imposed on the employer for the conduct of an identified employee unless the principal condoned, ratified, or consented to the alleged conduct.

Section 63: Limits of Liability Foster Care Outsourcing

Amends s. 409.1671, F.S., relating to limits of liability for child welfare lead CBC providers and subcontractors.

- Deletes legislative findings that minimum levels of insurance were to be in excess of the rights of recovery under s. 768.28 (sovereign immunity amounts).
- Reduces amounts of general liability coverage required by CBC contractors and their subcontractors to \$200,00 per claim or \$300,000 per incident from \$1 million per claim/\$3 million per incident
- In tort actions against CBC contractors and their subcontractors:
 - Reduces existing limitations on net economic damages to \$200,000 per liability claim, \$300,000 per liability incident from \$1 million per liability claim
 - Limits total economic damages recoverable by all claimants to \$500,000 in the aggregate
 - Limits noneconomic damages to \$300,000 per incident
 - Limits total economic damages recoverable by all claimants to \$500,000 in the aggregate
- Removes requirement that the limitations on damages increase 5 percent annually
- Requires that DCF use diligent efforts to ensure delivery of contracted services
 - DCF is not liable in tort for acts or omissions of CBC providers or their subcontractors
 - DCF may not require CBC providers or their subcontractors to indemnify the department or to add the department as an additional named insured on their insurance policies.

Section 64: Medical Physician Expert Witness Certificate

Creates s. 458.3167, F.S.

Specifies requirements for a medical physician licensed in another state or Canada to obtain a certificate from the Board of Medicine to provide expert medical opinions in Florida in a medical malpractice action. The board is granted rulemaking authority to implement the requirements to issue the certificate.

Section 65: Expert Witness Disciplinary Action for Medical Physicians

Amends s. 458.331, F.S.

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Establishes grounds for physician disciplinary action for the act of providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of medicine.

Section 66: Osteopath Expert Witness Certificate

Creates s. 459.0078, F.S.

Specifies requirements for an osteopath licensed in another state or Canada to obtain a certificate from the Board of Osteopathic Medicine to provide expert medical opinions in Florida in a medical malpractice action. The board is granted rulemaking authority to implement the requirements to issue the certificate.

Section 67: Expert Witness Disciplinary Action for Osteopaths

Amends s. 459.015, F.S.

Establishes grounds for physician disciplinary action for the act of providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of osteopathic medicine.

Section 68: Medical Negligence, Standards of Recovery, Expert Witness

Amends s. 766.102, F.S.

If a medical or osteopathic physician is a party against whom, or on whose behalf, expert testimony about the prevailing professional standard of care is offered, the expert witness must otherwise meet the requirements of this section and be licensed as a medical or osteopathic physician, or must possess a valid expert witness certificate.

Section 69: Pleading in Medical Negligence Cases

Amends s. 766.104, F.S.

Provides that if the cause of action for medical malpractice requires the plaintiff to establish the breach of a standard of care other than negligence in order to impose liability or to secure medical negligence damages, the presuit investigation and certification required by attorneys must demonstrate grounds for a good-faith belief that the requirement is met.

Section 70: Notice Before Filing Action for Medical Negligence

Amends s. 766.106, F.S.

Specifies that immunity from civil liability arising from participation in the presuit screening process does not prohibit expert witnesses from being subject to disciplinary action by the Board of Medicine or the Board of Osteopathic Medicine.

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Section 71: Health Care Providers and Agency Relationship (conforming)

Amends s. 766.1115, F.S.

Conforms this section to sovereign immunity provisions for the state not-for-profit college or university owning or operating a medical school that appear in section 75 of the bill.

Section 72: Standard of Care for Medicaid Providers

Creates s. 766.1183, F.S., relating to standard of care for Medicaid providers.

- Modified Recovery of Civil Damages - Specifies that the liability of health care providers who provide covered medical services to Medicaid recipients is limited to \$200,000 per claimant or \$300,000 per occurrence for any cause of action arising out of the rendering of, or the failure to render, medical services to a Medicaid recipient, unless the claimant proves that the provider acted in a wrongful manner. A claimant may still obtain a judgment in excess of \$200,000/\$300,000. The claimant may report the judgment to and seek the excess amount from the Legislature.
- However, a provider may still be liable for amounts in excess of \$200,000 or \$300,000 if a claimant proves that the provider acted in a wrongful manner.
- Only the existing limitations on damages in a medical malpractice action (limitation on damages passed during the 2003 Tort Reform) would apply if the claimant proved that the health care provider acted in a wrongful manner when rendering or failing to render medical services to a Medicaid recipient.
- Standard of care for imposing liability on provider greater than \$200,000 (\$300,000) is modified – Medical malpractice claimant who is a Medicaid recipient must prove that the provider acted in a wrongful manner. “Wrongful manner” is defined to mean an act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of humans rights, safety, or property. The modified standard of care conforms to the standard of care used when the waiver of sovereign immunity is not extended to state officers, employees, or agents under s. 768.28(9)(a), F.S.
- Burden of Proof – Shifts from greater weight of the evidence to a more demanding standard of clear and convincing evidence for the claimant to prove that the provider acted in a wrongful manner in order to impose liability in excess of \$200,000 per claimant (\$300,000 per occurrence). Plaintiffs can still recover damages from the provider up to \$200,000 (\$300,000) if they can prove their case at the existing burden of proof (greater weight of evidence) which applies to all medical malpractice actions.
- Existing damage caps from 2003 Tort Reform will continue to apply to medical malpractice plaintiffs who are Medicaid recipients.

Section 73: Standard of Care for LIP Recipients / Primary Care Services

Creates s. 766.1184, F.S.

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- “Low income pool recipient” is defined as a low income individual who is uninsured or underinsured and who receives primary care services from a provider which are delivered exclusively using funding received by that provider under proviso language (appropriation 191 in 2010-2011 fiscal year General Appropriations Act) to establish new or expand existing primary care clinics for low income persons who are uninsured or underinsured.
- “Provider” is defined as a health care provider under the Medical Malpractice Act which received funding under proviso language (appropriation 191 in 2010-2011 fiscal year General Appropriations Act) to establish new or expand existing primary care clinics for low income persons who are uninsured or underinsured. The term includes persons or entities for whom the provider is vicariously liable; and persons or entities whose liability is based solely on such persons or entities being vicariously liable for the actions of the provider.
- Modified Recovery of Civil Damages – Specifies that the liability of health care providers who provide covered medical services to low income recipients is limited to \$200,000 per claimant or \$300,000 per occurrence for any cause of action arising out of the rendering of, or the failure to render, primary care services to a low income pool recipient, unless the claimant proves that the provider acted in a wrongful manner. A claimant may still obtain a judgment in excess of \$200,000/\$300,000. The claimant may report the judgment to and seek the excess amount from the Legislature.
- However, a provider may still be liable for amounts in excess of \$200,000 or \$300,000 if a claimant proves that the provider acted in a wrongful manner.
- The existing limitations on damages in a medical malpractice action (limitation on damages passed during the 2003 Tort Reform) would apply if the claimant proved that the health care provider acted in a wrongful manner when rendering or failing to render primary care services to a low income recipient. .
- For the limitations on civil damages to apply, the provider must develop, implement, and maintain policies and procedures to: ensure that the appropriated funds (Specific appropriation 191) are used exclusively to serve low income persons who are uninsured or underinsured; determine whether funds (Specific appropriation 191) are being used to provide primary care services to a particular person; and identify whether an individual receiving primary care services is a low income recipient to whom the limitations apply. The provider also must provide notice of the statutory provisions prior to providing services to the recipient. Additionally, the provider must be in compliance with the agreement between the provider and the Agency for Health Care Administration governing the receipt of the funds.
- Standard of care for imposing liability on provider greater than \$200,000 (\$300,000) is modified – Medical malpractice claimant who is a low income pool recipient must prove that the provider acted in a wrongful manner. “Wrongful manner” is defined to mean an act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of

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humans rights, safety, or property. The modified standard of care conforms to the standard of care used when the waiver of sovereign immunity is not extended to state officers, employees, or agents under s. 768.28(9)(a), F.S.

- Burden of Proof – Shifts from greater weight of the evidence to a more demanding standard of clear and convincing evidence for the claimant to prove that the provider acted in a wrongful manner in order to impose liability in excess of \$200,000 per claimant (\$300,000 per occurrence). Plaintiffs can still recover from the provider damages up to \$200,000 (\$300,000) if they can prove their case at the existing burden of proof (greater weight of evidence) which applies to all medical malpractice actions.
- Existing damage caps from 2003 Tort Reform will continue to apply to medical malpractice plaintiffs who are low income pool recipients.

Section 74: Presuit Investigation for Medical Negligence Claims

Amends s. 766.203, F.S.

Provides that if the cause of action for medical malpractice requires the plaintiff to establish the breach of a standard of care other than negligence in order to impose liability or to secure medical negligence damages, then the presuit investigation and certification required for the claimant and the defendant must ascertain that reasonable grounds exist to believe that the requirement is met.

Section 75: Sovereign Immunity for State Not-for-Profit College or University Owning/Operating Medical School

Amends s. 768.28, F.S.

Extends the waiver of sovereign immunity to a state not-for-profit college or university that owns or operates an accredited medical school and its employees and agents when the employees or agents of the medical school are providing patient services at a teaching hospital that has an affiliation agreement with the medical school. The medical school and its employees when providing patient services to patients at the public teaching hospital would be considered an agent of the public teaching hospital for purposes of sovereign immunity.

Requires patients to be provided notice that employees of the medical school are considered agents of the public teaching hospital for purposes of the waiver of sovereign immunity. Additionally patients are provided notice that the exclusive remedy for any injury or damages suffered based on the acts of the employees of the medical school when providing patient services at the public teaching hospital is under the sovereign immunity provisions.

Section 76: Sovereign Immunity for Private Medical School Employees

Non-statutory provision of law.

Establishes a legislature declaration that there is an overpowering public necessity for extending the state's sovereign immunity to a college or university that owns and operates a medical school and the employees and agents of such

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private colleges or universities when providing medical services in public teaching hospitals and that there is no alternative method of meeting such public necessity.

Section 77: Sovereign Immunity for Shands

Amends s. 1004.41, F.S.

Extends the waiver of sovereign immunity to Shands Teaching Hospital and its subsidiaries. The bill provides that Shands Teaching Hospital and Clinics, Inc.; Shands Jacksonville Medical Center, Inc.; Shands Jacksonville Healthcare, Inc.; and any not-for-profit subsidiary of such entities are instrumentalities of the state for purposes of sovereign immunity. The University of Florida Board of Trustees has the right to control Shands Teaching Hospital and Clinics, Inc. Shands Teaching Hospital and Clinics, Inc., and any not-for-profit subsidiaries are conclusively deemed corporations primarily acting as instrumentalities of the State of Florida.

Section 78: Repeal of Obsolete or Redundant Statutes (technical)

Effective October 1, 2013, repeals the following sections of Florida Statutes:

- 409.9121
- 409.919
- 624.915

Section 79: Technical

Transfers and renumbers section 409.942, F.S., relating to the electronic benefit transfer program, to s. 414.29, F.S.

Section 80: Technical

Amends s. 443.111, F.S., to make a technical statutory reference change.

Sections 81 and 82: Technical

Perform clean-up duty by transferring and renumbering several sections of Florida Statutes.

Section 83: AHCA Reorganization

Non-statutory provision of law.

Requires AHCA to submit a reorganizational plan to the Governor, the Speaker of the House of Representative, and the President of the Senate by January 1, 2012, which converts the agency from a check-writing and fraud-chasing agency into a contract compliance and monitoring agency.

Section 84: Medicaid Withdrawal

Non-statutory provision of law.

Effective December 1, 2011, if the Legislature has not received a letter from the Governor stating that the federal CMS has approved the waivers necessary to

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implement the Medicaid managed care reforms contained in this act, the State of Florida shall withdraw from the Medicaid program effective December 31, 2011.

Section 85: Severability

Non-statutory provision of law.

If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 86: Effective Date

This act shall take effect upon becoming a law.

**Time Line
Medicaid Bill**

No.	Activity	Duration	Begin	End	Comments
1.0	Request new waiver(s) or amendments to existing waivers.				
1.1	Analyze legislation and determine waiver(s) needed.	1 month	6/1/2011	7/1/2011	
1.2	Prepare waiver requests and amendments	1 month	7/1/2011	7/31/2011	
1.3	Submit waiver requests and amendments	1 day	7/31/2011	8/1/2011	
1.4	Federal review and approval	4 months	8/1/2011	11/30/2011	Indication of approval expected at 3 month point
1.5	Expect federal approval		11/30/2011	12/1/2011	
1.6	If federal approval not received, request continued federal funding	1 day	12/1/2011	12/1/2011	
1.7	If waiver(s) not approved and funding not provided, notify federal agency that state intends to proceed with state-only funded program.	1 month	12/1/2011	12/31/2011	
1.8	Send notice to potentially affected beneficiaries of potential reduction or termination of services.	20 days	12/1/2011	12/20/2011	
1.9	Begin implementation of state-only funded program or waiver program, depending on federal approval.		12/31/2011	12/31/2011	
2.0	Develop and submit amendments to the Medicaid State Plan				
2.1	Analyze legislation and determine provisions that can be implemented through Medicaid State Plan amendment	1 month	6/1/2011	6/30/2011	
2.2	Submit state plan amendments for quarter	by end of quarter	7/1/2011	9/30/2011	
2.3	Schedule submissions of amendments effective in later quarters	as needed	10/1/2011	as appropriate	
3.0	Conduct Invitations to Negotiate				287.057(3)
3.1	ITN(s) for Managed Care Medical Assistance		6/1/2011	12/31/2011	
3.1.1	Preliminary development of ITN criteria	1 month	6/1/2011	7/1/2011	
3.1.2	Obtain approval to use ITN as procurement method	10 days	6/20/2011	7/1/2011	
3.1.3	ITN Document development	1 month	7/1/2011	7/31/2011	287.057(3)(a)
3.1.4	Develop data book for Managed Care Medical Assistance Program	By 7/15		7/15/2011	
3.1.5	Publish data book		7/15/2011	7/15/2011	409.965(1)(b)
3.1.6	ITN Internal Review	2 weeks	7/31/2011	8/15/2011	
3.1.7	Advertisement	40 days	8/15/2011	9/24/2011	
3.1.8	Document Receipt/Opening of Responses	1 day	9/24/2011	9/25/2011	119.071(1)(b)1.a.
3.1.9	Initial evaluation of responses and recommendation for short list	2 weeks	9/25/2011	10/9/2011	287.057(3)(b)

**Time Line
Medicaid Bill**

No.	Activity	Duration	Begin	End	Comments
3.1.10	Advertise short list	72 hours	10/9/2011	10/12/2011	120.57(3)
3.1.11	Preliminary Negotiations	2 weeks	10/12/2011	10/26/2011	
3.1.12	Negotiators develop recommendations and make recommendation	20 days	10/26/2011	11/15/2011	
3.1.13	Advertise Intent to Award	72 hours	11/15/2011	11/18/2011	
3.1.14	Develop draft contract(s)	1 week	11/18/2011	11/25/2011	
3.1.15	Review and approval of contract(s)	3 weeks	11/25/2011	12/16/2011	
3.1.16	Execution of contract(s) by provider and Secretary	2 weeks	12/16/2011	12/31/2011	
3.2	ITN(s) for Managed Long Term Care		8/20/2011	3/31/2012	
3.2.1	Preliminary development of ITN criteria	1 month	8/20/2011	9/19/2011	
3.2.2	Obtain approval to use ITN as procurement method	10 days	9/19/2011	9/29/2011	
3.2.3	ITN Document development	1 month	9/29/2011	10/30/2011	287.057(3)(a)
3.2.4	Develop data book for Managed Long Term Care Program	by 7/15		7/15/2011	
3.2.5	Publish data book		7/15/2011	7/15/2011	409.965(1)(b)
3.2.6	ITN Internal Review	2 weeks	10/30/2011	11/14/2011	
3.2.7	Advertisement	40 days	11/14/2011	12/24/2011	
3.2.8	Document Receipt/Opening of Responses	1 day	12/24/2011	12/27/2011	119.071(1)(b)1.a.
3.2.9	Initial evaluation of responses and recommendation for short list	2 weeks	12/27/2011	1/10/2012	287.057(3)(b)
3.2.10	Advertise short list	72 hours	1/10/2012	1/13/2012	120.57(3)
3.2.11	Preliminary Negotiations	2 weeks	1/13/2012	1/27/2012	
3.2.12	Negotiators develop recommendations and make recommendation	50 days	1/27/2012	2/16/2012	
3.2.13	Advertise Intent to Award	72 hours	2/16/2012	2/19/2012	
3.2.14	Develop draft contract(s)	1 week	2/19/2012	2/26/2012	
3.2.15	Review and approval of contract(s)	3 weeks	2/26/2012	3/18/2012	
3.2.16	Execution of contract(s) by provider and Secretary	2 weeks	3/18/2012	3/31/2012	
4.0	Implement Managed Care Medical Assistance	12 months	12/31/2011	12/31/2012	
5.0	Implement Managed Long Term Care	12 months	3/31/2012	3/31/2013	

Note: Steps in the ITN procurement process will take place simultaneously in each region per s. 409.965

Materials to be
provided at the meeting