The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BUDGET SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS
Senator Negron, 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 Negron, 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		

28-01190A-11

A bill to be entitled

An act relating to health and human services; 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; 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; amending s. 393.0661, F.S.; conforming provisions to changes made by the act; 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; amending s. 409.016, F.S.; conforming provisions to changes made by the act; creating 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; 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; 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; 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; amending s. 409.901, F.S.; revising definitions relating to Medicaid; 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; 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; creating s. 409.9022, F.S.; specifying procedures to be implemented by a state agency if the Medicaid expenditures exceed appropriations; amending s. 409.903, F.S.; conforming provisions to changes made by the act; deleting obsolete provisions; 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;

amending s. 409.905, F.S.; conforming provisions to changes made by the act; requiring prior authorization for home health services; 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; amending ss. 409.9062 and 409.907, F.S.; conforming provisions to changes made by the act; 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; 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; 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; amending s. 409.915, F.S.; conforming provisions to changes made by the act; transferring, renumbering, and amending s. 409.9301, F.S.; conforming provisions to changes made by the act; amending s. 409.9126, F.S.; conforming a cross-reference; providing a directive to the Division of Statutory Revision; creating s. 409.961, F.S.; providing for statutory construction of provisions relating to Medicaid managed care; creating s. 409.962, F.S.; providing definitions; creating 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; creating 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; creating 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; creating 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; creating 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; creating 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; creating 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; creating 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; creating s. 409.971, F.S.; providing for managed care medical assistance; providing deadlines for beginning and finalizing implementation; creating s. 409.972, F.S.; establishing minimum services for the managed medical assistance; providing for optional services; authorizing plans to customize benefit packages; creating 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; creating 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; creating s. 409.975, F.S.; establishing

minimum services for managed long-term care; creating s. 409.976, F.S.; providing criteria for the selection of plans to provide managed long-term care; creating 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; creating 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; 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.; 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; 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; 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; 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; 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; 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; creating 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; 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; 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; 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; amending s. 766.106, F.S.; clarifying that a physician acting as an expert witness is subject to disciplinary actions; amending s. 766.1115, F.S.; conforming provisions to changes made by the act; creating 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; creating 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; 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; 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; 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; 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; 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; amending s. 443.111, F.S.; conforming a cross-reference; directing the Agency for Health Care Administration to submit a reorganization plan to the Legislature; providing for the state's withdrawal from the Medicaid program under certain circumstances; providing for severability; providing

an effective date.

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

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

216.262 Authorized positions.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) 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 particular facts and circumstances of the case, entitle the provider or health plan to the amount awarded, if any.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.—

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(b) The Florida Healthy Kids Corporation shall:

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

2. Arrange for the collection of any voluntary

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

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

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

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

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

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

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

administrative services to the corporation.

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

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

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

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

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

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

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

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

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

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:

(a) Medicaid.~~;~~

(b) Medikids as created in s. 409.8132.~~;~~

(c) The Florida Healthy Kids Corporation as created in s. 409.8115. ~~624.91;~~

(d) Employer-sponsored group health insurance plans approved under this part. ~~ss. 409.810-409.821; and~~

(e) The Children's Medical Services network ~~established in chapter 391~~.

Section 11. Subsection (4) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.—

(4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127, 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, ~~and~~ 409.9205, 409.987, 409.988, and 409.989 apply to the administration of the Medikids program component of the Florida Kidcare program, except that s. 409.987 ~~409.9122~~ applies to Medikids as modified by ~~the provisions of~~ subsection (7).

Section 12. Subsection (1) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.—

(1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare program, benefits available under Medicaid and Medikids include those goods and services provided under the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, as administered in this state by the agency. This includes those mandatory Medicaid services authorized under s. 409.905 and optional Medicaid services

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

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

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

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

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

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

(2) The department shall:

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

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

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

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

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

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

1006.06 School food service programs.—

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

(a) At a minimum:

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

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

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

regular and periodic basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Proceeds, as defined in this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

in part IV of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

409.902 Designated single state agency; eligibility determinations; rules ~~payment requirements; program title; release of medical records~~.—

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

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

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

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

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

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

1. Citizenship or immigration status must be verified. For

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

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

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

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

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

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

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

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

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

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

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

409.9021 Conditions for Medicaid ~~Forfeiture of~~ eligibility ~~agreement~~.~~—~~As a condition of Medicaid eligibility, subject to federal regulation and approval:~~,~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

409.9022 Limitations on Medicaid expenditures.—

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

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

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

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

(a) Reduction in administrative costs.

(b) Elimination of optional benefits.

(c) Elimination of optional eligibility groups.

(d) Reduction to institutional and provider reimbursement rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) A child who has not attained the age of 19 who has been determined eligible for the Medicaid program is deemed to be eligible for a total of 6 months, regardless of changes in circumstances other than attainment of the maximum age. ~~Effective January 1, 1999,~~ A child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is deemed to be eligible for a total of 12 months regardless of changes in circumstances other than attainment of the maximum age.

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

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

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

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

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

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

rates, lengths 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 General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.

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

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

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

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

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

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

(b) The agency shall implement a comprehensive utilization

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

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

1. The services are ordered by a physician.

2. The written prescription for the services is signed and dated by the recipient's physician before the development of a plan of care and before any request requiring prior authorization.

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

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

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

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

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

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

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

retrospective review program.

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

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

population at that institution if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

physician.

(8) COMMUNITY MENTAL HEALTH SERVICES.—

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

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

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

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

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

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

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

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

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

(13) HOME AND COMMUNITY-BASED SERVICES.—

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

~~for~~ in the General Appropriations Act.

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

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

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

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

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

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

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

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

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

same services.

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

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

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

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

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

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

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

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

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

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

(27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may

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

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

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

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

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

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

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

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

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

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

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

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

(a) Inpatient care.—

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

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

b.~~2.~~ Recognition of the costs of graduate medical education.

c.~~3.~~ Other methodologies recognized in the General Appropriations Act.

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

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

(b) Outpatient care.—

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

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

b.~~2.~~ Renal dialysis services.

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

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

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

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

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

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

(2) NURSING HOME CARE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Advanced registered nurse practitioner services.

(b) Birth center services.

(c) Chiropractic services.

(d) Community mental health services.

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

(f) Durable medical equipment.

(g) Hearing services.

(h) Occupational therapy for Medicaid recipients under age

21.

(i) Optometric services.

(j) Orthodontic services.

(k) Personal care for Medicaid recipients under age 21.

(l) Physical therapy for Medicaid recipients under age 21.

(m) Physician assistant services.

(n) Podiatric services.

(o) Portable X-ray services.

(p) Private-duty nursing for Medicaid recipients under age 21.

(q) Registered nurse first assistant services.

(r) Respiratory therapy for Medicaid recipients under age 21.

(s) Speech therapy for Medicaid recipients under age 21.

(t) Visual services.

(4) MANAGED CARE SERVICES.—Subject to any limitations or directions provided ~~for~~ in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and~~, beginning September 1, 1995,~~ ~~shall~~ include age-band differentials in such calculations.

(5) AMBULATORY SURGICAL CENTERS.—An ambulatory surgical center shall be reimbursed the lesser of the amount billed by

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

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

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

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

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

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

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

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

(12) PHYSICIAN SERVICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ss. 409.9071 and 1011.70 for the federal portion of the school district's allowable costs to deliver the services, based on the reimbursement schedule. The school district shall determine the costs for delivering services as authorized in ss. 409.9071 and 1011.70 for which the state match will be certified. Reimbursement of school-based providers is contingent on such providers being enrolled as Medicaid providers and meeting the qualifications contained in 42 C.F.R. s. 440.110, unless otherwise waived by the federal Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~. Speech therapy providers who are certified through the Department of Education pursuant to rule 6A-4.0176, Florida Administrative Code, are eligible for reimbursement for services that are provided on school premises. Any employee of the school district who has been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines is ~~shall be~~ exempt from any agency requirements relating to criminal background checks.

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

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

Appropriations Act.

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

1. Inpatient hospitals.

2. Outpatient hospitals.

3. Nursing homes.

4. County health departments.

5. Community intermediate care facilities for the developmentally disabled.

6. Prepaid health plans.

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

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

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

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

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

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

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

409.9081 Copayments.—

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

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

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

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

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

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

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

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

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

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

(4) The agency may contract with:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a fee-for-service or prepaid basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—

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

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

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

(a) Is a resident of this state;

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

(c) Is eligible for Medicare;

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

(e) Requests to be enrolled in the program.

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

409.9126 Children with special health care needs.—

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

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

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

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

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

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

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

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

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

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

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

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

Section 37. Section 409.963, Florida Statutes, is created

to read:

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

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

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

Services.

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

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

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

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

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

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

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

3. Medical services to pregnant women.

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

5. Services provided under the Healthy Start waiver.

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

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

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

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

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

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

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

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

(a) Women who are eligible only for family planning

services.

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

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

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

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

(f) Persons who are residing in a nursing home facility or are considered residents 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) A person who is eligible for services under the Medicaid program who has access to health care coverage through an employer-sponsored health plan. Such person may not receive Medicaid services under the fee-for-service program but may use Medicaid financial assistance to pay the cost of premiums for the employer-sponsored health plan. For purposes of this paragraph, access to health care coverage through an employer-sponsored health plan means that the Medicaid financial assistance available to the person is sufficient to pay the premium for the employer-sponsored health plan for the eligible person and his or her Medicaid eligible family members.

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

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

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

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

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

(b) Persons eligible for refugee assistance.

(3) 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 though the Medicaid fee-for-service program as provided under part III of this chapter.

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

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

by qualified plans.

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

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

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

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

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

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

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

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

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

Marion, and Sumter counties.

(f) Region 6, which consists of Pasco and Pinellas counties.

(g) Region 7, which consists of Flagler, Putnam, St. Johns, and Volusia counties.

(h) Region 8, which consists of Alachua, Bradford, Gilchrist, Levy, and Union counties.

(i) Region 9, which consists of Orange and Osceola counties.

(j) Region 10, which consists of Hardee, Highlands, and Polk counties.

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

(l) Region 12, which consists of DeSoto, Manatee, and Sarasota counties.

(m) Region 13, which consists of Hillsborough County.

(n) Region 14, which consists of Bay, Calhoun, Gulf, Holmes, Jackson, and Washington counties.

(o) Region 15, which consists of Palm Beach County.

(p) Region 16, which consists of Broward County.

(q) Region 17, which consists of Brevard and Seminole counties.

(r) Region 18, which consists of Indian River, Martin, Okeechobee, and St. Lucie counties.

(s) Region 19, which consists of Charlotte, Collier, Glades, Hendry, and Lee counties.

(3) The invitation to negotiate must specify the criteria and the relative weight of the criteria to be used for determining the acceptability of a reply and guiding the

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

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

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

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

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

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

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

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

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

program area.

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

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

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

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

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

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

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

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

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

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

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

(5) The Children's Medical Services Network authorized

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

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

409.966 Plan contracts.—

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

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

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

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

necessary, the contract must require:

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

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

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

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

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

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

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

contract.

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

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

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

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

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

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

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

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

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

5. Designation of a program integrity compliance officer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Federally qualified health centers.

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

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

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

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

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

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

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

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

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

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

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

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

3. Maintaining continuity of care for each assigned enrollee.

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

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

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

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

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

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

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

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

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

Section 42. Section 409.968, Florida Statutes, is created

to read:

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

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

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

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

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

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

409.969 Enrollment; disenrollment; grievance procedure.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

409.972 Managed care medical assistance services.—

(1) Qualified plans providing managed care medical assistance must, at a minimum, cover the following services:

(a) Ambulatory patient services.

(b) Dental services for a recipient who is under age 21.

(c) Dental services as provided in s. 627.419(7) for a recipient who is 21 years of age or older.

(d) Dialysis services.

(e) Durable medical equipment and supplies.

(f) Early periodic screening diagnosis and treatment services, hearing services and hearing aids, and vision services and eyeglasses for enrollees under age 21.

(g) Emergency services.

(h) Family planning services.

(i) Hearing services for a recipient who is under age 21.

(j) Hearing services that are medically indicated for a recipient who is 21 years of age or older.

(k) Home health services.

(l) Hospice services.

(m) Hospital inpatient services.

(n) Hospital outpatient services.

(o) Laboratory and imaging services.

(p) Maternity and newborn care and birth center services.

(q) Mental health services, substance abuse disorder services, and behavioral health treatment.

(r) Prescription drugs.

(s) Primary care service, referred specialty care services, preventive services, and wellness services.

(t) Skilled nursing facility or inpatient rehabilitation

facility services.

(u) Transplant services.

(v) Transportation to access covered services.

(w) Vision services for a recipient who is under age 21.

(x) Vision services that are medically indicated for a recipient who is 21 years of age or older.

(2) Subject to specific appropriations, the agency may make payments for services that are optional.

(3) Qualified plans may customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The agency shall evaluate the proposed benefit packages to ensure that services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.

(4) Managed care medical assistance services provided under this section must be medically necessary and provided in accordance with state and federal law. This section does not prevent the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or from making any other adjustments necessary to comply with the availability of funding and any limitations or directions provided in the General Appropriations Act, chapter 216, or s. 409.9022.

Section 47. Section 409.973, Florida Statutes, is created to read:

409.973 Managed long-term care.—

(1) Qualified plans providing managed care medical assistance may also participate in the managed long-term care component of the Medicaid managed care program. Unless otherwise

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

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

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

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

409.974 Recipient eligibility for managed long-term care.—

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

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

Medicaid by reason of a disability.

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

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

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

(b) The Aged and Disabled Adult Waiver.

(c) The Adult Day Health Care Waiver.

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

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

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

(g) The Channeling Services Waiver for Frail Elders.

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

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

409.975 Managed long-term care services.—

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

(a) The services listed in s. 409.972.

(b) Nursing facility services.

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

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

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

409.976 Qualified managed long-term care plans.—

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

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

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

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

invitation to negotiate by November 14, 2011.

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

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

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

1. Adult day centers.
2. Adult family care homes.
3. Assisted living facilities.
4. Health care services pools.
5. Home health agencies.
6. Homemaker and companion services.
7. Community Care for the Elderly lead agencies.
8. Nurse registries.
9. Nursing homes.

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

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

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

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

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

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

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

(1) Adult day centers.

(2) Adult family care homes.

(3) Assisted living facilities.

(4) Health care services pools.

(5) Home health agencies.

(6) Homemaker and companion services.

(7) Community Care for the Elderly lead agencies.

(8) Nurse registries.

(9) Nursing homes.

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

409.978 CARES program screening; levels of care.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

special health needs of the recipient; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

430.2053 Aging resource centers.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) Assist enrollees 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 in each of the regions pursuant to s. 409.973(2).

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

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

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

(c) Expertise in information and referral activities.

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

(e) Financial solvency and stability.

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

(g) Commitment to adequate staffing by qualified personnel

to effectively perform all functions.

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

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

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

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

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

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

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

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

(a) Community care for the elderly.

(b) Home care for the elderly.

(c) Contracted services.

(d) Alzheimer's disease initiative.

(e) Aged and disabled adult Medicaid waiver.

(f) Assisted living for the frail elderly Medicaid waiver.

(g) Older Americans Act.

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

(a) Minimum standards for financial operation, including audit procedures.

(b) Procedures for monitoring and sanctioning of service providers.

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

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

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

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

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

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

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

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

center.

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

(14)~~(16)~~ If any of the state activities described in this section are outsourced, ~~either~~ in part or in whole, the contract executing the outsourcing must ~~shall~~ mandate that the contractor or its subcontractors shall, ~~either~~ physically or virtually, execute the provisions of the memorandum of understanding instead of the state entity whose function the contractor or subcontractor now performs.

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

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

(16)~~(19)~~(a) Once an aging resource center is operational, the department, in consultation with the agency, may develop capitation rates for any of the programs administered through the aging resource center. Capitation rates for programs must

~~shall~~ be based on the historical cost experience of the state in providing those same services to the population age 60 or older residing within each area served by an aging resource center. Each capitated rate may vary by geographic area as determined by the department.

(b) The department and the agency may determine for each area served by an aging resource center whether it is appropriate, consistent with federal and state laws and regulations, to develop and pay separate capitated rates for each program administered through the aging resource center or to develop and pay capitated rates for service packages which include more than one program or service administered through the aging resource center.

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

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

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

~~(a) Medicaid nursing home services.~~

~~(b) Medicaid transportation services.~~

~~(c) Medicaid hospice care services.~~

~~(d) Medicaid intermediate care services.~~

~~(e) Medicaid prescribed drug services.~~

~~(f) Medicaid assistive care services.~~

~~(g) Any other long-term-care program or Medicaid service.~~

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

Section 60. Paragraphs (c) and (d) of subsection (3) of section 39.407, Florida Statutes, are amended to read:

39.407 Medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.—

(3)

(c) Except as provided in paragraphs (b) and (e), the department must file a motion seeking the court's authorization to initially provide or continue to provide psychotropic medication to a child in its legal custody. The motion must be supported by a written report prepared by the department which describes the efforts made to enable the prescribing physician to obtain express and informed consent to provide ~~for providing~~ the medication to the child and other treatments considered or recommended for the child. ~~In addition,~~ The motion must also be supported by the prescribing physician's signed medical report providing:

1. The name of the child, the name and range of the dosage of the psychotropic medication, and the ~~that there is a~~ need to prescribe psychotropic medication to the child based upon a diagnosed condition for which such medication is being prescribed.

2. A statement indicating that the physician has reviewed all medical information concerning the child which has been provided.

3. A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.

4. An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.

5. Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.

6. For a child 10 years of age or younger who is in an out-of-home placement, the results of a review of the administration of the medication by a child psychiatrist who is licensed under chapter 458 or chapter 459. The review must be provided to the child and the parent or legal guardian before final express and informed consent is given. The review must include a determination of the following:

a. The presence of a genetic psychiatric disorder or a

family history of a psychiatric disorder;

b. Whether the cause of a psychiatric disorder is organic or environmental; and

c. The likelihood of the child being an imminent danger to self or others.

(d)~~1.~~ The department must notify all parties of the proposed action taken under paragraph (c) in writing or by whatever other method best ensures that all parties receive notification of the proposed action within 48 hours after the motion is filed. If any party objects to the department's motion, that party shall file the objection within 2 working days after being notified of the department's motion. If any party files an objection to the authorization of the proposed psychotropic medication, the court shall hold a hearing as soon as possible before authorizing the department to initially provide or to continue providing psychotropic medication to a child in the legal custody of the department.

1. At such hearing and notwithstanding s. 90.803, the medical report described in paragraph (c) is admissible in evidence. The prescribing physician need not attend the hearing or testify unless the court specifically orders such attendance or testimony, or a party subpoenas the physician to attend the hearing or provide testimony.

2. If, after considering any testimony received, the court finds that the department's motion and the physician's medical report meet the requirements of this subsection and that it is in the child's best interests, the court may order that the department provide or continue to provide the psychotropic medication to the child without additional testimony or

evidence.

3. At any hearing held under this paragraph, the court shall ~~further~~ inquire of the department as to whether additional medical, mental health, behavioral, counseling, or other services are being provided to the child by the department which the prescribing physician considers to be necessary or beneficial in treating the child's medical condition and which the physician recommends or expects to provide to the child in concert with the medication. The court may order additional medical consultation, including consultation with the MedConsult line at the University of Florida, if available, or require the department to obtain a second opinion within a reasonable timeframe as established by the court, not to exceed 21 calendar days, ~~after such order~~ based upon consideration of the best interests of the child. The department must make a referral for an appointment for a second opinion with a physician within 1 working day.

4. The court may not order the discontinuation of prescribed psychotropic medication if such order is contrary to the decision of the prescribing physician unless the court first obtains an opinion from a licensed psychiatrist, if available, or, if not available, a physician licensed under chapter 458 or chapter 459, stating that more likely than not, discontinuing the medication would not cause significant harm to the child. If, however, the prescribing psychiatrist specializes in mental health care for children and adolescents, the court may not order the discontinuation of prescribed psychotropic medication unless the required opinion is also from a psychiatrist who specializes in mental health care for children and adolescents.

The court may also order the discontinuation of prescribed psychotropic medication if a child's treating physician, licensed under chapter 458 or chapter 459, states that continuing the prescribed psychotropic medication would cause significant harm to the child due to a diagnosed nonpsychiatric medical condition.

5. If a child who is in out-of-home placement is 10 years of age or younger, psychotropic medication may not be authorized by the court absent a finding of a compelling governmental interest. In making such finding, the court shall review the psychiatric review described in subparagraph (c)6.

6.~~2.~~ The burden of proof at any hearing held under this paragraph shall be by a preponderance of the evidence.

Section 61. Section 400.023, Florida Statutes, is reordered and amended to read:

400.023 Civil enforcement.—

(1) A ~~Any~~ resident who ~~whose~~ alleges negligence or a violation of rights as specified in this part has ~~are violated shall have~~ a cause of action against the licensee or its management company, as identified in the state application for nursing home licensure. However, the cause of action may not be asserted individually against an officer, director, owner, including an owner designated as having a controlling interest on the state application for nursing home licensure, or agent of a licensee or management company unless, following an evidentiary hearing, the court determines there is sufficient evidence in the record or proffered by the claimant which establishes a reasonable basis for finding that the person or entity breached, failed to perform, or acted outside the scope

of duties as an officer, director, owner, or agent, and that the breach, failure to perform, or action outside the scope of duties is a legal cause of actual loss, injury, death, or damage to the resident.

(2) The action may be brought by the resident or his or her guardian, by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death.

(5) If the action alleges a claim for the resident's rights or for negligence that:

(a) Caused the death of the resident, the claimant must ~~shall be required to~~ elect ~~either~~ survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the claimant elects wrongful death damages, total noneconomic damages may not exceed $250,000, regardless of the number of claimants.

(b) ~~If the action alleges a claim for the resident's rights or for negligence that~~ Did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident.

(3) The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for any violation of the rights of a resident or for negligence.

(10) Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy may ~~is entitled to~~ recover the costs of the action, and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall

be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 400.023-400.0238 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of rights specified in s. 400.022. This section does not preclude theories of recovery not arising out of negligence or s. 400.022 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 400.023-400.0238.

(6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part alleges ~~alleging~~ a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

(12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~ create strict liability. A violation of the rights set forth in s. 400.022 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency is ~~shall~~

~~be~~ evidence of negligence but may ~~shall~~ not be considered negligence per se.

(7)~~(3)~~ In any claim brought pursuant to this section, a licensee, person, or entity has ~~shall have~~ a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(9)~~(4)~~ In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse has a ~~shall have the~~ duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse is ~~shall be~~ that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(8)~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical negligence of any physician rendering care or treatment to the resident except for the administrative services of a medical director as required in this part. ~~Nothing in~~ This subsection does not ~~shall be construed to~~ protect a licensee, person, or entity from liability for failure to provide a resident with appropriate observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care by nursing staff.

(4)~~(6)~~ The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this part to the agency ~~for Health Care Administration~~ at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. ~~The requirement of~~ Providing a copy of

the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

(11) ~~(7)~~ An action under this part for a violation of rights or negligence ~~recognized herein~~ is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death of the resident.

Section 62. Subsections (1), (2), and (3) of section 400.0237, Florida Statutes, are amended to read:

400.0237 Punitive damages; pleading; burden of proof.—

(1) In any action ~~for damages~~ brought under this part, a ~~no~~ claim for punitive damages is not ~~shall be~~ permitted unless, based on admissible ~~there is a reasonable showing by~~ evidence ~~in the record or~~ proffered by the claimant, ~~which would provide~~ a reasonable basis for recovery of such damages is demonstrated upon applying the criteria set forth in this section. The defendant may proffer admissible evidence to refute the claimant's proffer of evidence to recover punitive damages. The trial judge shall conduct an evidentiary hearing and weigh the admissible evidence proffered by the claimant and the defendant to ensure that there is a reasonable basis to believe that the claimant, at trial, will be able to demonstrate by clear and convincing evidence that the recovery of such damages is warranted. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. ~~The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages.~~ ~~No~~ Discovery of financial worth may not ~~shall~~ proceed until after

the trial judge approves the pleading on ~~concerning~~ punitive damages ~~is permitted~~.

(2) A defendant, including the licensee or management company, against whom punitive damages is sought may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct, or engaged in conduct that constituted gross negligence, and that conduct contributed to the loss, damages, or injury suffered by the claimant ~~the defendant was personally guilty of intentional misconduct or gross negligence~~. As used in this section, the term:

(a) "Intentional misconduct" means that the defendant against whom a claim for punitive damages is sought had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(b) "Gross negligence" means that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

(3) In the case of vicarious liability of an employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an identified employee or agent unless ~~only if~~ the conduct of the employee or agent meets the criteria specified in subsection (2) and officers, directors, or managers of the actual employer corporation or legal entity condoned, ratified, or consented to the specific

conduct as alleged by the claimant in subsection (2).~~:~~

~~(a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;~~

~~(b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or~~

~~(c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.~~

Section 63. Paragraphs (f), (h), (j), and (l) of subsection (1) and subsection (2) of section 409.1671, Florida Statutes, are amended to read:

409.1671 Foster care and related services; outsourcing.—

(1)

(f)~~1.~~ The Legislature finds that the state has traditionally provided foster care services to children who are ~~have been~~ the responsibility of the state. As such, foster children have not had the right to recover for injuries beyond the limitations specified in s. 768.28. The Legislature has also determined that foster care and related services need to be outsourced ~~pursuant to this section~~ and that the provision of such services is of paramount importance to the state. The purpose for such outsourcing is to increase the level of safety, security, and stability of children who are or become the responsibility of the state.

1. One of the components necessary to secure a safe and stable environment for such children is for ~~that~~ private providers to maintain adequate liability insurance. ~~As~~ Such~~,~~

insurance needs to be available and remain available to nongovernmental foster care and related services providers without the resources of such providers being significantly reduced by the cost of maintaining such insurance. To ensure that these resources are not significantly reduced, specified limits of liability are necessary for eligible lead community-based providers and subcontractors engaged in the provision of services previously performed by the department.

2. The Legislature further finds that, by requiring the following minimum levels of insurance, children in outsourced foster care and related services will gain increased protection ~~and rights of recovery in the event of injury than provided for in s. 768.28~~.

(h) Other than an entity to which s. 768.28 applies, an ~~any~~ eligible lead community-based provider~~, as defined in paragraph (e),~~ or its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability coverage for a minimum of $200,000 per claim or $300,000 per incident ~~a minimum of $1 million per claim/$3 million per incident in general liability insurance coverage~~.

1. The eligible lead community-based provider must also require ~~that~~ staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities to obtain minimum bodily injury liability insurance on their personal automobiles in the amount of $100,000 per claim or~~,~~ $300,000 per incident~~, on their personal automobiles~~. In lieu of personal motor vehicle insurance, the lead community-based provider's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile

liability coverage~~. This insurance provides liability insurance~~ for automobiles that the provider uses in connection with the provider's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the provider or a member of the employee's household ~~but only~~ while the automobiles are used in connection with the provider's business. The nonowned automobile coverage ~~for the provider~~ applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the provider shall be primary insurance, and the nonowned automobile coverage of the provider acts as excess insurance to the primary insurance. The provider shall provide a minimum limit of $1 million in nonowned automobile coverage.

2. In any tort action brought against ~~such~~ an eligible lead community-based provider or employee, net economic damages are ~~shall be~~ limited to $200,000 ~~$1 million~~ per liability claim, $300,000 per liability incident, and $100,000 per automobile claim, including, but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action brought against an eligible lead community-based provider, the total economic damages recoverable by all claimants is limited to $500,000 in the aggregate. In any tort action brought against such an eligible lead community-based provider, noneconomic damages are ~~shall be~~ limited to $200,000 per claim and $300,000 per incident. In any tort action brought against an eligible lead community-based provider, the total noneconomic damages recoverable by all claimants are limited to $500,000 in the aggregate.

3. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76. The lead community-based provider is ~~shall~~ not ~~be~~ liable in tort for the acts or omissions of its subcontractors or the officers, agents, or employees of its subcontractors.

(j) Any subcontractor of an eligible lead community-based provider~~, as defined in paragraph (e),~~ which is a direct provider of foster care and related services to children and families, and its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability insurance coverage for a minimum of $200,000 per claim or $300,000 ~~$1 million per claim/$3 million~~ per incident ~~in general liability insurance coverage~~.

1. The subcontractor of an eligible lead community-based provider must also require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities obtain minimum bodily injury liability insurance in the amount of $100,000 per claim, $300,000 per incident, on their personal automobiles. In lieu of personal motor vehicle insurance, the subcontractor's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the subcontractor uses in connection with the subcontractor's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the subcontractor or a member of the

employee's household but only while the automobiles are used in connection with the subcontractor's business. The nonowned automobile coverage for the subcontractor applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the subcontractor is ~~shall be~~ primary insurance, and the nonowned automobile coverage of the subcontractor acts as excess insurance to the primary insurance. The subcontractor shall provide a minimum limit of $1 million in nonowned automobile coverage.

2. In any tort action brought against such subcontractor or employee, net economic damages shall be limited to $200,000 ~~$1 million~~ per liability claim, $300,000 per liability incident, and $100,000 per automobile claim, including, but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action brought against such subcontractor or employee, the total economic damages recoverable by all claimants is limited to $500,000 in the aggregate. In any tort action brought against such subcontractor, noneconomic damages shall be limited to $200,000 per claim and $300,000 per incident. In any tort action brought against such subcontractor or employee, the total noneconomic damages recoverable by all claimants is limited to $500,000 in the aggregate.

3. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76.

~~(l) The Legislature is cognizant of the increasing costs of goods and services each year and recognizes that fixing a set amount of compensation actually has the effect of a reduction in compensation each year. Accordingly, the conditional limitations on damages in this section shall be increased at the rate of 5 percent each year, prorated from the effective date of this paragraph to the date at which damages subject to such limitations are awarded by final judgment or settlement.~~

(2)~~(a)~~ The department may contract for the delivery, administration, or management of protective services, the services specified in subsection (1) relating to foster care, and other related services or programs, as appropriate.

(a) The department shall use diligent efforts to ensure that ~~retain responsibility for the quality of~~ contracted services and programs ~~and shall ensure that services~~ are of high quality and delivered in accordance with applicable federal and state statutes and regulations. However, the department is not liable in tort for the acts or omissions of eligible lead community-based providers or their officers, agents, or employees, or liable in tort for the acts or omissions of the subcontractors of eligible lead community-based care providers or their officers, agents, or employees. Further, the department may not require eligible lead community-based providers or their subcontractors to indemnify the department for the department's acts or omissions or require eligible lead-based community providers or their subcontractors to include the department as an additional insured on an insurance policy.

(b) The department shall ~~must~~ adopt written policies and procedures for monitoring the contract for the delivery of

services by lead community-based providers. These policies and procedures must, at a minimum, address the evaluation of fiscal accountability and program operations, including provider achievement of performance standards, provider monitoring of subcontractors, and timely followup of corrective actions for significant monitoring findings related to providers and subcontractors. The ~~These~~ policies and procedures must also include provisions for reducing the duplication of the department's program monitoring activities both internally and with other agencies, to the extent possible. The department's written procedures must ensure that the written findings, conclusions, and recommendations from monitoring the contract ~~for services of lead community-based providers~~ are communicated to the director of the provider agency as expeditiously as possible.

(c) ~~(b)~~ Persons employed by the department in the provision of foster care and related services whose positions are being outsourced under this statute shall be given hiring preference by the provider, if provider qualifications are met.

Section 64. Section 458.3167, Florida Statutes, is created to read:

458.3167 Expert witness certificate.—

(1) A physician who holds an active and valid license to practice allopathic medicine in any other state or in Canada, who submits an application form prescribed by the board to obtain a certificate to provide expert testimony and pays the application fee, and who has not had a previous expert witness certificate revoked by the board shall be issued a certificate to provide expert testimony.

(2) A physician possessing an expert witness certificate may use the certificate only to give a verified written medical expert opinion as provided in s. 766.203 and to provide expert testimony concerning the prevailing professional standard of care for medical negligence litigation pending in this state against a physician licensed under this chapter or chapter 459.

(3) An application for an expert witness certificate must be approved or denied within 5 business days after receipt of a completed application. An application that is not approved or denied within the required time period is deemed approved. An applicant seeking to claim certification by default shall notify the board, in writing, of the intent to rely on the default certification provision of this subsection. In such case, s. 458.327 does not apply, and the applicant may provide expert testimony as provided in subsection (2).

(4) All licensure fees, other than the initial certificate application fee, including the neurological injury compensation assessment, are waived for those persons obtaining an expert witness certificate. The possession of an expert witness certificate alone does not entitle the physician to engage in the practice of medicine as defined in s. 458.305.

(5) The board shall adopt rules to administer this section, including rules setting the amount of the expert witness certificate application fee, which may not exceed $50. An expert witness certificate expires 2 years after the date of issuance.

Section 65. Subsection (11) is added to section 458.331, Florida Statutes, present paragraphs (oo) through (qq) of subsection (1) of that section are redesignated as paragraphs (pp) through (rr), respectively, and a new paragraph (oo) is

added to that subsection, to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(oo) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine.

(11) The purpose of this section is to facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Section 66. Section 459.0078, Florida Statutes, is created to read:

459.0078 Expert witness certificate.—

(1) A physician who holds an active and valid license to practice osteopathic medicine in any other state or in Canada, who submits an application form prescribed by the board to obtain a certificate to provide expert testimony and pays the application fee, and who has not had a previous expert witness certificate revoked by the board shall be issued a certificate to provide expert testimony.

(2) A physician possessing an expert witness certificate may use the certificate only to give a verified written medical expert opinion as provided in s. 766.203 and to provide expert testimony concerning the prevailing professional standard of care for medical negligence litigation pending in this state against a physician licensed under this chapter or chapter 458.

(3) An application for an expert witness certificate must

be approved or denied within 5 business days after receipt of a completed application. An application that is not approved or denied within the required time period is deemed approved. An applicant seeking to claim certification by default shall notify the board, in writing, of the intent to rely on the default certification provision of this subsection. In such case, s. 459.013 does not apply, and the applicant may provide expert testimony as provided in subsection (2).

(4) All licensure fees, other than the initial certificate application fee, including the neurological injury compensation assessment, are waived for those persons obtaining an expert witness certificate. The possession of an expert witness certificate alone does not entitle the physician to engage in the practice of osteopathic medicine as defined in s. 459.003.

(5) The board shall adopt rules to administer this section, including rules setting the amount of the expert witness certificate application fee, which may not exceed $50. An expert witness certificate expires 2 years after the date of issuance.

Section 67. Subsection (11) is added to section 459.015, Florida Statutes, present paragraphs (qq) through (ss) of subsection (1) of that section are redesignated as paragraphs (rr) through (tt), respectively, and a new paragraph (qq) is added to that subsection, to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(qq) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of osteopathic

medicine.

(11) The purpose of this section is to facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Section 68. Present subsection (12) of section 766.102, Florida Statutes, is redesignated as subsection (13), and a new subsection (12) is added to that section, to read:

766.102 Medical negligence; standards of recovery; expert witness.—

(12) If a physician licensed under chapter 458 or chapter 459 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 physician under chapter 458 or chapter 459, or must possess a valid expert witness certificate issued under s. 458.3167 or s. 459.0078.

Section 69. Subsection (1) of section 766.104, Florida Statutes, is amended to read:

766.104 Pleading in medical negligence cases; claim for punitive damages; authorization for release of records for investigation.—

(1) An ~~No~~ action ~~shall be filed~~ for personal injury or wrongful death arising out of medical negligence, whether in tort or in contract, may not be filed unless the attorney filing the action has made a reasonable investigation, as permitted by the circumstances, to determine that there are grounds for a good faith belief that there has been negligence in the care or

treatment of the claimant.

(a) The complaint or initial pleading must ~~shall~~ contain a certificate of counsel that such reasonable investigation gave rise to a good faith belief that grounds exist for an action against each named defendant. For purposes of this section, good faith may be shown ~~to exist~~ if the claimant or his or her counsel has received a written opinion, ~~which shall~~ not ~~be~~ subject to discovery by an opposing party, of an expert as defined in s. 766.102 that there appears to be evidence of medical negligence. If the court determines that the ~~such~~ certificate of counsel was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court shall award attorney's fees and taxable costs against claimant's counsel~~,~~ and ~~shall~~ submit the matter to The Florida Bar for disciplinary review of the attorney.

(b) If the cause of action requires the plaintiff to establish the breach of a standard of care other than negligence in order to impose liability or secure specified damages arising out of the rendering of, or the failure to render, medical care or services, and the plaintiff intends to pursue such liability or damages, the investigation and certification required by this subsection must demonstrate grounds for a good faith belief that the requirement is satisfied.

Section 70. Subsection (5) of section 766.106, Florida Statutes, is amended to read:

766.106 Notice before filing action for medical negligence; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.—

(5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion, written document, report, or other work product generated by the presuit screening process is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process. This subsection does not prohibit a physician licensed under chapter 458 or chapter 459, or a physician who holds a certificate to provide expert testimony under s. 458.3167 or s. 459.0078, who submits a verified written expert medical opinion from being subject to disciplinary action pursuant to s. 456.073.

Section 71. Subsection (11) of section 766.1115, Florida Statutes, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

(11) APPLICABILITY.—

(a) This section applies to incidents occurring on or after April 17, 1992.

(b) This section does not apply to any health care contract entered into by the Department of Corrections which is subject to s. 768.28(10)(a).

(c) This section does not apply to any affiliation agreement or other contract subject to s. 768.28(10)(f).

(d) ~~Nothing in~~ This section does not reduce or limit ~~in any way reduces or limits~~ the rights of the state or any of its agencies or subdivisions to any benefit currently provided under s. 768.28.

Section 72. Section 766.1183, Florida Statutes, is created to read:

766.1183 Standard of care for Medicaid providers.—

(1) As used in this section:

(a) The terms "applicant," "medical assistance," "medical services," and "Medicaid recipient" have the same meaning as in s. 409.901.

(b) The term "provider" means a health care provider as defined in s. 766.202 or an entity that qualifies for an exemption under s. 400.9905(4)(e). The term includes:

1. Any person or entity for whom a provider is vicariously liable; and

2. Any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a provider.

(c) The term "wrongful manner" means in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property, and shall be construed in conformity with the standard set forth in s. 768.28(9)(a).

(2) A provider is not liable in excess of $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, except as provided under subsection (3). However, a judgment may be claimed and rendered in excess of the amounts set forth in this subsection. That portion of the judgment that exceeds these amounts may be reported to the Legislature, but may be paid in part or in whole by the state only by further act of the Legislature.

(3) A provider may be liable for an amount in excess of $200,000 per claimant or $300,000 per occurrence only if the claimant pleads and proves, by clear and convincing evidence, that the provider acted in a wrongful manner. If the claimant so pleads, the court, after a reasonable opportunity for discovery, shall conduct a hearing before trial to determine if there is a reasonable basis in evidence to conclude that the provider acted in a wrongful manner. A claim for wrongful conduct is not permitted, to the extent it exceeds the amounts set forth in subsection (2), unless the claimant makes the showing required by this subsection.

(4) At the time an application for medical assistance is submitted, the Department of Children and Family Services shall furnish the applicant with written notice of the provisions of this section.

(5) This section does not limit or exclude the application of any law, including s. 766.118, which places limitations upon the recovery of civil damages.

(6) This section does not apply to any claim for damages to which s. 768.28 applies.

Section 73. Section 766.1184, Florida Statutes, is created to read:

766.1184 Standard of care; low-income pool recipient.—

(1) As used in this section, the term:

(a) "Low-income pool recipient" means 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 accompanying specific appropriation 191 of the

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.

(b) "Provider" means a health care provider, as defined in s. 766.202, which received funding under proviso language accompanying specific appropriation 191 of the fiscal year 2010-11 General Appropriations Act to establish new or expand existing primary care clinics for low-income persons who are uninsured or underinsured. The term includes:

1. Any person or entity for whom the provider is vicariously liable; and

2. Any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of the provider.

(c) "Wrongful manner" means in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property, and shall be construed in conformity with the standard set forth in s. 768.28(9)(a).

The funding of the provider's primary care clinic must have been awarded pursuant to a plan approved by the Legislative Budget Commission, and must be the subject of an agreement between the provider and the Agency for Health Care Administration, following the competitive solicitation of proposals to use low-income pool grant funds to provide primary care services in general acute hospitals, county health departments, faith-based and community clinics, and federally qualified health centers to uninsured or underinsured persons.

(2) A provider is not liable in excess of $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, except as provided under subsection (3). However, a judgment may be claimed and rendered in excess of the amounts set forth in this subsection. That portion of the judgment that exceeds these amounts may be reported to the Legislature, but may be paid in part or in whole by the state only by further act of the Legislature.

(3) A provider may be liable for an amount in excess of $200,000 per claimant or $300,000 per occurrence only if the claimant pleads and proves, by clear and convincing evidence, that the provider acted in a wrongful manner. If the claimant so pleads, the court, after a reasonable opportunity for discovery, shall conduct a hearing before trial to determine if there is a reasonable basis in evidence to conclude that the provider acted in a wrongful manner. A claim for wrongful conduct is not permitted, to the extent it exceeds the amounts set forth in subsection (2), unless the claimant makes the showing required by this subsection.

(4) In order for this section to apply, the provider must:

(a) Develop, implement, and maintain policies and procedures to:

1. Ensure that funds described in subsection (1) are used exclusively to serve low-income persons who are uninsured or underinsured;

2. Determine whether funds described in subsection (1) are being used to provide primary care services to a particular person; and

3. Identify whether an individual receiving primary care services is a low-income pool recipient to whom the provisions of this section apply.

(b) Furnish a low-income pool recipient with written notice of the provisions of this section before providing primary care services to the recipient.

(c) Be in compliance with the terms of any agreement between the provider and the Agency for Health Care Administration governing the receipt of the funds described in subsection (1).

(5) This section does not limit or exclude the application of any law, including s. 766.118, which places limitations upon the recovery of civil damages.

(6) This section does not apply to any claim for damages to which s. 768.28 applies.

Section 74. Subsection (5) is added to section 766.203, Florida Statutes, to read:

766.203 Presuit investigation of medical negligence claims and defenses by prospective parties.—

(5) STANDARDS OF CARE.—If the cause of action that is the basis for the litigation requires the plaintiff to establish the breach of a standard of care other than negligence in order to impose liability or secure specified damages arising out of the rendering of, or the failure to render, medical care or services, and the plaintiff intends to pursue such liability or damages, the presuit investigations required of the claimant and the prospective defendant by this section must ascertain that there are reasonable grounds to believe that the requirement is satisfied.

Section 75. Paragraph (b) of subsection (9) of section 768.28, Florida Statutes, is amended, and paragraph (f) is added to subsection (10) of that section, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(9)

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any health care provider when providing services pursuant to s. 766.1115; ~~,~~ any member of the Florida Health Services Corps, as defined in s. 381.0302, who provides uncompensated care to medically indigent persons referred by the Department of Health; any state not-for-profit college or university that owns or operates an accredited medical school and its employees or agents when providing services pursuant to paragraph (10)(f); ~~,~~ and any public defender or her or his employee or agent, including, among others, an assistant public defender and an investigator.

(10)

(f) For purposes of this section, any state not-for-profit college or university that owns or operates an accredited medical school, or any of its employees or agents, and that has agreed in an affiliation agreement or other contract to provide, or permit its employees or agents to provide, patient services as agents of a teaching hospital is considered an agent of the teaching hospital while acting within the scope of and pursuant

to guidelines established in the contract. To the extent allowed by law, the contract must provide for the indemnification of the state, up to the limits set out in this chapter, by the agent for any liability incurred which was caused by the negligence of the college or university or its employees or agents.

1. For purposes of this paragraph, the term:

a. "Employee or agent" means an officer, employee, agent, or servant of a state not-for-profit college or university that owns or operates an accredited medical school, including, but not limited to, the faculty of the medical school, any health care practitioner or licensee as defined in s. 456.001 for which the college or university is vicariously liable, and the staff or administrator of the medical school.

b. "Patient services" mean:

(I) Comprehensive health care services as defined in s. 641.19, including any related administrative service, provided to patients in a teaching hospital or in a health care facility owned by a state not-for-profit college or university that owns or operates an accredited medical school, pursuant to an affiliation agreement or other contract with a teaching hospital;

(II) Training and supervision of interns, residents, and fellows providing patient services in a teaching hospital or in a health care facility owned by a state not-for-profit college or university that owns or operates an accredited medical school, pursuant to an affiliation agreement or other contract with a teaching hospital;

(III) Participation in medical research protocols; or

(IV) Training and supervision of medical students in a

teaching hospital or in a health care facility owned by a state not-for-profit college or university that owns or operates an accredited medical school, pursuant to an affiliation agreement or other contract with a teaching hospital.

c. "Teaching hospital" means a teaching hospital as defined in s. 408.07 which is owned or operated by the state, a county or municipality, a public health trust, a special taxing district, a governmental entity having health care responsibilities, or a not-for-profit entity that operates such facilities as an agent of the state or a political subdivision of the state under a lease or other contract.

2. The teaching hospital or the medical school, or its employees or agents, must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the college or university that owns or operates the medical school and the employees or agents of that college or university are acting as agents of the teaching hospital and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the teaching hospital, the college or university that owns or operates the medical school, or the employees or agents of the college or university while acting within the scope of duties pursuant to the affiliation agreement or other contract with a teaching hospital is by commencement of an action pursuant to the provisions of this section.

3. This paragraph does not designate any employee providing contracted patient services in a teaching hospital as an employee or agent of the state for purposes of chapter 440.

Section 76. Legislative findings and intent.—

(1) The Legislature finds that:

(a) Access to high quality, comprehensive, and affordable health care for all persons in this state is a necessary state goal, and that teaching hospitals play an intrinsic and essential role in providing that access.

(b) Graduate medical education, provided by colleges and universities that own or operate private medical schools, helps provide the comprehensive specialty training needed by medical school graduates to develop and refine the skills essential to the provision of high quality health care for our state residents. Much of that education and training is provided in public teaching hospitals under the direct supervision of medical faculty employees who provide guidance, training, and oversight, and serve as role models to their students.

(c) A large proportion of medical care is provided in large public teaching hospitals that serve as safety nets for many indigent and underserved patients who otherwise might not receive the medical help they need. Resident physician training that takes place in such hospitals provides much of the care provided to this population. Medical faculty, supervising such training and care, are a vital link between educating and training resident physicians and ensuring the provision of quality care for indigent and underserved residents. Physicians that assume this role are often called upon to juggle the demands of patient care, teaching, research, health policy, and budgetary issues related to the programs they administer.

(d) The employees or agents of private colleges and universities that enter into affiliation agreements or contracts with public teaching hospitals to provide patient services do

not have the same level of protection against liability claims as public teaching hospitals and their employees and agents who provide the same patient services to the same patients. Thus, these private colleges and universities and their employees and agents are disproportionately affected by claims arising out of alleged medical malpractice and other allegedly negligent acts. Given the recent growth in medical schools and medical education programs and ongoing efforts to support, strengthen, and increase physician residency training positions and medical faculty in both existing and newly designated teaching hospitals, this exposure and the consequent disparity in liability exposure will continue to increase. The vulnerability of these colleges and universities to claims of medical malpractice will only add to the current physician workforce crisis in Florida, and can only be alleviated through legislative action.

(e) Ensuring that the employees and agents of private colleges and universities that own or operated medical schools are able to continue to treat patients, provide graduate medical education, supervise medical students, engage in research, and provide administrative support and services in public teaching hospitals is an overwhelming public necessity.

(2) The Legislature intends that:

(a) Employees and agents of private colleges and universities that own or operate medical schools, who provide patient services as agents of a public teaching hospital be immune from lawsuits in the same manner and to the same extent as employees and agents of public teaching hospitals in this state under existing law, and that such colleges and

universities and their employees and agents not be held personally liable in tort or named as a party defendant in an action while providing patient services in a public teaching hospital, unless such services are provided in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) Private colleges and universities that own or operate medical schools and that permit their employees or agents to provide patient services in public teaching hospitals pursuant to an affiliation agreement or other contract, be afforded sovereign immunity protections under s. 768.28, Florida Statutes.

(3) The Legislature declares that there is an overpowering public necessity for extending the state's sovereign immunity to private colleges and universities, and their employees or agents, which own or operate medical schools and provide medical services in public teaching hospitals, and that there is no alternative method of meeting such public necessity.

Section 77. Section 1004.41, Florida Statutes, is amended to read:

1004.41 University of Florida; J. Hillis Miller Health Center.—

(1) There is established the J. Hillis Miller Health Center at the University of Florida, including campuses at Gainesville and Jacksonville and affiliated teaching hospitals, which shall include the following colleges:

(a) College of Dentistry.

(b) College of Public Health and Health Professions.

(c) College of Medicine.

(d) College of Nursing.

(e) College of Pharmacy.

(f) College of Veterinary Medicine and related teaching hospitals.

(2) Each college of the health center shall be ~~so~~ maintained and operated so as to comply with the standards approved by a nationally recognized association for accreditation.

(3)(a) The University of Florida Health Center Operations and Maintenance Trust Fund shall be administered by the University of Florida Board of Trustees. Funds shall be credited to the trust fund from the sale of goods and services performed by the University of Florida Veterinary Medicine Teaching Hospital. The purpose of the trust fund is to support the instruction, research, and service missions of the University of Florida College of Veterinary Medicine.

(b) Notwithstanding ~~the provisions of~~ s. 216.301, and pursuant to s. 216.351, any balance in the trust fund at the end of any fiscal year shall remain in the trust fund and ~~shall~~ be available for carrying out the purposes of the trust fund.

(4)(a) The University of Florida Board of Trustees shall lease the hospital facilities of the health center known as the Shands Teaching Hospital and Clinics on the Gainesville campus of the University of Florida and all furnishings, equipment, and other chattels or choses in action used in the operation of the hospital, to Shands Teaching Hospital and Clinics, Inc., a private not-for-profit corporation organized ~~solely~~ for the primary purpose of supporting ~~operating~~ the University of Florida Board of Trustees' health affairs mission of community

service and patient care, education and training of health professionals, and clinical research. In furtherance of that purpose, Shands Teaching Hospital and Clinics, Inc., shall operate the hospital and ancillary health care facilities as deemed ~~of the health center and other health care facilities and programs determined to be~~ necessary by the board of Shands Teaching Hospital and Clinics, Inc. ~~the nonprofit corporation.~~ The rental for the hospital facilities shall be an amount equal to the debt service on bonds or revenue certificates issued solely for capital improvements to the hospital facilities or as otherwise provided by law.

(b) The University of Florida Board of Trustees shall provide in the lease or by separate contract or agreement with Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit corporation~~ for the following:

1. Approval of the articles of incorporation of Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit corporation~~ by the University of Florida Board of Trustees and the governance of that ~~the~~ not-for-profit corporation by a board of directors appointed, subject to removal, and chaired by the President of the University of Florida, or his or her designee, and vice chaired by the Vice President for Health Affairs of the University of Florida, or his or her designee.

2. The use of hospital facilities and personnel in support of community service and patient care, ~~the~~ research programs, and ~~of the~~ teaching roles ~~role~~ of the health center.

3. The continued recognition of the collective bargaining units and collective bargaining agreements as currently composed and recognition of the certified labor organizations

representing those units and agreements.

4. The use of hospital facilities and personnel in connection with research programs conducted by the health center.

5. Reimbursement to the hospital for indigent patients, state-mandated programs, underfunded state programs, and costs to the hospital for support of the teaching and research programs of the health center. Such reimbursement shall be appropriated to either the health center or the hospital each year by the Legislature after review and approval of the request for funds.

(c) The University of Florida Board of Trustees may, with the approval of the Legislature, increase the hospital facilities or remodel or renovate them, provided that the rental paid by the hospital for such new, remodeled, or renovated facilities is sufficient to amortize the costs thereof over a reasonable period of time or fund the debt service for any bonds or revenue certificates issued to finance such improvements.

(d) The University of Florida Board of Trustees is authorized to provide to Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit corporation leasing the hospital facilities~~ and its not-for-profit subsidiaries and affiliates comprehensive general liability insurance including professional liability from a self-insurance trust program established pursuant to s. 1004.24.

(e) Shands Teaching Hospital and Clinics, Inc., may, in support of the health affairs mission of the University of Florida Board of Trustees and with its prior approval, create for-profit or not-for-profit corporate subsidiaries and

affiliates, or both. The University of Florida Board of Trustees, which may act through the President of the University of Florida or his or her designee, 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, pursuant to s. 768.28(2), for purposes of sovereign immunity.

(f)~~(e)~~ If ~~In the event that~~ the lease of the hospital facilities to Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit corporation~~ is terminated for any reason, the University of Florida Board of Trustees shall resume management and operation of the hospital facilities. In such event, the University of Florida Board of Trustees is authorized to utilize revenues generated from the operation of the hospital facilities to pay the costs and expenses of operating the hospital facility for the remainder of the fiscal year in which such termination occurs.

(5)~~(f)~~ Shands Jacksonville Medical Center, Inc., and its parent Shands Jacksonville Healthcare, Inc., are private not-for-profit corporations organized primarily to support the health affairs mission of the University of Florida Board of Trustees in community service and patient care, education and training of health affairs professionals, and clinical research. Shands Jacksonville Medical Center, Inc., is a teaching hospital affiliated with the University of Florida Board of Trustees, located on the Jacksonville Campus of the University of Florida. Shands Jacksonville Medical Center, Inc., and Shands Jacksonville Healthcare, Inc., may, in support of the health

affairs mission of the University of Florida Board of Trustees and with its prior approval, create for-profit or not-for-profit corporate subsidiaries and affiliates, or both.

(a) The University of Florida Board of Trustees, which may act through the President of the University of Florida or his or her designee, has the right to control Shands Jacksonville Medical Center, Inc., and Shands Jacksonville Healthcare, Inc. Shands Jacksonville Medical Center, Inc., Shands Jacksonville Healthcare, Inc., and any not-for-profit subsidiary of Shands Jacksonville Medical Center, Inc., are conclusively deemed corporations primarily acting as instrumentalities of the state, pursuant to s. 768.28(2), for purposes of sovereign immunity.

(b) The University of Florida Board of Trustees is authorized to provide to Shands Jacksonville Healthcare, Inc., and its not-for-profit subsidiaries and affiliates and any successor corporation that acts in support of the board of trustees, comprehensive general liability coverage, including professional liability, from the self-insurance programs established pursuant to s. 1004.24.

Section 78. Sections 409.9121, 409.919, and 624.915, Florida Statutes, are repealed.

Section 79. Section 409.942, Florida Statutes, is transferred and renumbered as section 414.29, Florida Statutes.

Section 80. Paragraph (a) of subsection (1) of section 443.111, Florida Statutes, is amended to read:

443.111 Payment of benefits.—

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

(a) Benefits are payable by mail or electronically. Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a system for the payment of benefits by electronic funds transfer, including, but not limited to, debit cards, electronic payment cards, or any other means of electronic payment that the agency deems to be commercially viable or cost-effective. Commodities or services related to the development of such a system shall be procured by competitive solicitation, unless they are purchased from a state term contract pursuant to s. 287.056. The agency shall adopt rules necessary to administer the system.

Section 81. Sections 409.944, 409.945, and 409.946, Florida Statutes, are transferred and renumbered as sections 163.464, 163.465, and 163.466, Florida Statutes, respectively.

Section 82. Sections 409.953 and 409.9531, Florida Statutes, are transferred and renumbered as sections 402.81 and 402.82, Florida Statutes, respectively.

Section 83. The Agency for Health Care administration shall submit an reorganizational plan to the Governor, the Speaker of the House of Representatives, 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. Effective December 1, 2011, if the Legislature has not received a letter from the Governor stating that the federal Centers for Medicare and Medicaid has approved the waivers necessary to 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. 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. 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

Health and Human Services Bill 28-01190A-11

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.

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.

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.

- 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.

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.

- 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.

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

- 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.

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 though 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.

- 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.

<u>Section 42: Plan Payment and IGTs</u>
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.

<u>Section 43: Enrollment, Disenrollment, and Grievances</u>
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

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.

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.

Provides for an4 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 manage 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.

- 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

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.

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.

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.

- "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

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

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

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