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

29 providing that the rates shall be subject to certain
30 limits or ceilings; providing that limits or ceilings may
31 be provided in the General Appropriations Act; directing
32 the agency to develop a plan to convert inpatient hospital
33 rates to a prospective payment system that categorizes
34 each case into diagnosis related groups; providing for a
35 report; amending s. 409.911, F.S.; providing for
36 expiration of the Medicaid Low Income Pool Council;
37 amending s. 409.912, F.S.; providing payment requirements
38 for provider service networks; providing for the
39 expiration of various provisions of the section on
40 specified dates to conform to the reorganization of
41 Medicaid managed care; requiring the Agency for Health
42 Care Administration to contract on a prepaid or fixed-sum
43 basis with certain prepaid dental health plans; requiring
44 Medicaid-eligible children with open child welfare cases
45 who reside in AHCA area 10 to be enrolled in specified
46 capitated managed care plans; eliminating obsolete
47 provisions and updating provisions within the section;
48 amending ss. 409.91195 and 409.91196, F.S.; conforming
49 cross-references; repealing s. 409.91207, F.S.; relating
50 to the medical home pilot project; repealing s. 409.91211,
51 F.S.; relating to the Medicaid managed care pilot program;
52 amending s. 409.9122, F.S.; eliminating outdated
53 provisions; providing for the expiration of various
54 provisions of the section on specified dates to conform to
55 the reorganization of Medicaid managed care; requiring the
56 Agency for Health Care Administration to develop a process

57 to enable any recipient with access to employer sponsored
58 coverage to opt out of eligible plans in the Medicaid
59 program; requiring the agency, contingent on federal
60 approval, to enable recipients with access to other
61 coverage or related products providing access to specified
62 health care services to opt out of eligible plans in the
63 Medicaid program; requiring the agency to maintain and
64 operate the Medicaid Encounter Data System; requiring the
65 agency to conduct a review of encounter data and publish
66 the results of the review prior to adjusting rates for
67 prepaid plans; requiring the agency to establish a
68 designated payment for specified Medicare Advantage
69 Special Needs members; authorizing the agency to develop a
70 designated payment for Medicaid-only covered services for
71 which the state is responsible; requiring the agency to
72 establish, and managed care plans to use, a uniform method
73 of accounting for and reporting of medical and nonmedical
74 costs; authorizing the Agency for Health Care
75 Administration to create exceptions to mandatory
76 enrollment in managed care under specified circumstances;
77 providing that the agency shall contract with a provider
78 service network to function as a third party administrator
79 and managing entity for the MediPass program; providing
80 contract provisions; providing for the expiration of the
81 section on a specified date; amending s. 430.04, F.S.;
82 eliminating outdated provisions; requiring the Department
83 of Elderly Affairs to develop a transition plan for
84 specified elder and disabled adults receiving long-term

85 care Medicaid services when eligible plans become
86 available; providing for expiration thereof; amending s.
87 430.2053, F.S.; eliminating outdated provisions; providing
88 additional duties of aging resource centers; providing an
89 additional exception to direct services that may not be
90 provided by an aging resource center; providing for the
91 cessation of specified payments by the department as
92 eligible plans become available; providing for a
93 memorandum of understanding between the Agency for Health
94 Care Administration and aging resource centers under
95 certain circumstances; eliminating provisions requiring
96 reports; amending s. 641.386, F.S.; conforming a cross-
97 reference; repealing s. 430.701, F.S., relating to
98 legislative findings and intent and approval for action
99 relating to provider enrollment levels; repealing s.
100 430.702, F.S., relating to the Long-Term Care Community
101 Diversion Pilot Project Act; repealing s. 430.703, F.S.,
102 relating to definitions; repealing s. 430.7031, F.S.,
103 relating to nursing home transition program; repealing s.
104 430.704, F.S., relating to evaluation of long-term care
105 through the pilot projects; repealing s. 430.705, F.S.,
106 relating to implementation of long-term care community
107 diversion pilot projects; repealing s. 430.706, F.S.,
108 relating to quality of care; repealing s. 430.707, F.S.,
109 relating to contracts; repealing s. 430.708, F.S.,
110 relating to certificate of need; repealing s. 430.709,
111 F.S., relating to reports and evaluations; renumbering ss.
112 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and

113 409.9531, F.S., as ss. 402.81, 402.82, 402.83, 402.84,
114 402.85, 402.86, and 402.87, F.S., directing the Agency for
115 Health Administration to develop a plan to implement the
116 enrollment of the medically needy into managed care;
117 respectively; amending s. 443.111, F.S.; conforming a
118 cross-reference; providing contingent effective dates.
119
120 Be It Enacted by the Legislature of the State of Florida:
121
122 Section 1. Section 393.0661, Florida Statutes, is amended
123 to read:
124 393.0661 Home and community-based services delivery
125 system; comprehensive redesign.—The Legislature finds that the
126 home and community-based services delivery system for persons
127 with developmental disabilities and the availability of
128 appropriated funds are two of the critical elements in making
129 services available. Therefore, it is the intent of the
130 Legislature that the Agency for Persons with Disabilities shall
131 develop and implement a comprehensive redesign of the system.
132 (1) The redesign of the home and community-based services
133 system shall include, at a minimum, all actions necessary to
134 achieve an appropriate rate structure, client choice within a
135 specified service package, appropriate assessment strategies, an
136 efficient billing process that contains reconciliation and
137 monitoring components, and a redefined role for support
138 coordinators that avoids potential conflicts of interest and
139 ensures that family/client budgets are linked to levels of need.
140 (a) The agency shall use an assessment instrument that the

141 agency deems to be reliable and valid, including, but not
142 limited to, the Department of Children and Family Services'
143 Individual Cost Guidelines or the agency's Questionnaire for
144 Situational Information. The agency may contract with an
145 external vendor or may use support coordinators to complete
146 client assessments if it develops sufficient safeguards and
147 training to ensure ongoing inter-rater reliability.
148 (b) The agency, with the concurrence of the Agency for
149 Health Care Administration, may contract for the determination
150 of medical necessity and establishment of individual budgets.
151 (2) A provider of services rendered to persons with
152 developmental disabilities pursuant to a federally approved
153 waiver shall be reimbursed according to a rate methodology based
154 upon an analysis of the expenditure history and prospective
155 costs of providers participating in the waiver program, or under
156 any other methodology developed by the Agency for Health Care
157 Administration, in consultation with the Agency for Persons with
158 Disabilities, and approved by the Federal Government in
159 accordance with the waiver.
160 (3) The Agency for Health Care Administration, in
161 consultation with the agency, shall seek federal approval and
162 implement a four-tiered waiver system to serve eligible clients
163 through the developmental disabilities and family and supported
164 living waivers. The agency shall assign all clients receiving
165 services through the developmental disabilities waiver to a tier
166 based on the Department of Children and Family Services'
167 Individual Cost Guidelines, the agency's Questionnaire for
168 Situational Information, or another such assessment instrument

169 deemed to be valid and reliable by the agency; client
170 characteristics, including, but not limited to, age; and other
171 appropriate assessment methods.
172 (a) Tier one is limited to clients who have service needs
173 that cannot be met in tier two, three, or four for intensive
174 medical or adaptive needs and that are essential for avoiding
175 institutionalization, or who possess behavioral problems that
176 are exceptional in intensity, duration, or frequency and present
177 a substantial risk of harm to themselves or others. Total annual
178 expenditures under tier one may not exceed $150,000 per client
179 each year, provided that expenditures for clients in tier one
180 with a documented medical necessity requiring intensive
181 behavioral residential habilitation services, intensive
182 behavioral residential habilitation services with medical needs,
183 or special medical home care, as provided in the Developmental
184 Disabilities Waiver Services Coverage and Limitations Handbook,
185 are not subject to the $150,000 limit on annual expenditures.
186 (b) Tier two is limited to clients whose service needs
187 include a licensed residential facility and who are authorized
188 to receive a moderate level of support for standard residential
189 habilitation services or a minimal level of support for behavior
190 focus residential habilitation services, or clients in supported
191 living who receive more than 6 hours a day of in-home support
192 services. Total annual expenditures under tier two may not
193 exceed $53,625 per client each year.
194 (c) Tier three includes, but is not limited to, clients
195 requiring residential placements, clients in independent or
196 supported living situations, and clients who live in their

197 family home. Total annual expenditures under tier three may not
198 exceed $34,125 per client each year.
199 (d) Tier four includes individuals who were enrolled in
200 the family and supported living waiver on July 1, 2007, who
201 shall be assigned to this tier without the assessments required
202 by this section. Tier four also includes, but is not limited to,
203 clients in independent or supported living situations and
204 clients who live in their family home. Total annual expenditures
205 under tier four may not exceed $14,422 per client each year.
206 (e) The Agency for Health Care Administration shall also
207 seek federal approval to provide a consumer-directed option for
208 persons with developmental disabilities which corresponds to the
209 funding levels in each of the waiver tiers. The agency shall
210 implement the four-tiered waiver system beginning with tiers
211 one, three, and four and followed by tier two. The agency and
212 the Agency for Health Care Administration may adopt rules
213 necessary to administer this subsection.
214 (f) The agency shall seek federal waivers and amend
215 contracts as necessary to make changes to services defined in
216 federal waiver programs administered by the agency as follows:
217 1. Supported living coaching services may not exceed 20
218 hours per month for persons who also receive in-home support
219 services.
220 2. Limited support coordination services is the only type
221 of support coordination service that may be provided to persons
222 under the age of 18 who live in the family home.
223 3. Personal care assistance services are limited to 180
224 hours per calendar month and may not include rate modifiers.

225 Additional hours may be authorized for persons who have
226 intensive physical, medical, or adaptive needs if such hours are
227 essential for avoiding institutionalization.
228 4. Residential habilitation services are limited to 8
229 hours per day. Additional hours may be authorized for persons
230 who have intensive medical or adaptive needs and if such hours
231 are essential for avoiding institutionalization, or for persons
232 who possess behavioral problems that are exceptional in
233 intensity, duration, or frequency and present a substantial risk
234 of harming themselves or others. This restriction shall be in
235 effect until the four-tiered waiver system is fully implemented.
236 5. Chore services, nonresidential support services, and
237 homemaker services are eliminated. The agency shall expand the
238 definition of in-home support services to allow the service
239 provider to include activities previously provided in these
240 eliminated services.
241 6. Massage therapy, medication review, and psychological
242 assessment services are eliminated.
243 7. The agency shall conduct supplemental cost plan reviews
244 to verify the medical necessity of authorized services for plans
245 that have increased by more than 8 percent during either of the
246 2 preceding fiscal years.
247 8. The agency shall implement a consolidated residential
248 habilitation rate structure to increase savings to the state
249 through a more cost-effective payment method and establish
250 uniform rates for intensive behavioral residential habilitation
251 services.
252 9. Pending federal approval, the agency may extend current

253 support plans for clients receiving services under Medicaid
254 waivers for 1 year beginning July 1, 2007, or from the date
255 approved, whichever is later. Clients who have a substantial
256 change in circumstances which threatens their health and safety
257 may be reassessed during this year in order to determine the
258 necessity for a change in their support plan.
259 10. The agency shall develop a plan to eliminate
260 redundancies and duplications between in-home support services,
261 companion services, personal care services, and supported living
262 coaching by limiting or consolidating such services.
263 11. The agency shall develop a plan to reduce the
264 intensity and frequency of supported employment services to
265 clients in stable employment situations who have a documented
266 history of at least 3 years' employment with the same company or
267 in the same industry.
268 (4) The geographic differential for Miami-Dade, Broward,
269 and Palm Beach Counties for residential habilitation services
270 shall be 7.5 percent.
271 (5) The geographic differential for Monroe County for
272 residential habilitation services shall be 20 percent.
273 (6) Effective January 1, 2010, and except as otherwise
274 provided in this section, a client served by the home and
275 community-based services waiver or the family and supported
276 living waiver funded through the agency shall have his or her
277 cost plan adjusted to reflect the amount of expenditures for the
278 previous state fiscal year plus 5 percent if such amount is less
279 than the client's existing cost plan. The agency shall use
280 actual paid claims for services provided during the previous

281 fiscal year that are submitted by October 31 to calculate the
282 revised cost plan amount. If the client was not served for the
283 entire previous state fiscal year or there was any single change
284 in the cost plan amount of more than 5 percent during the
285 previous state fiscal year, the agency shall set the cost plan
286 amount at an estimated annualized expenditure amount plus 5
287 percent. The agency shall estimate the annualized expenditure
288 amount by calculating the average of monthly expenditures,
289 beginning in the fourth month after the client enrolled,
290 interrupted services are resumed, or the cost plan was changed
291 by more than 5 percent and ending on August 31, 2009, and
292 multiplying the average by 12. In order to determine whether a
293 client was not served for the entire year, the agency shall
294 include any interruption of a waiver-funded service or services
295 lasting at least 18 days. If at least 3 months of actual
296 expenditure data are not available to estimate annualized
297 expenditures, the agency may not rebase a cost plan pursuant to
298 this subsection. The agency may not rebase the cost plan of any
299 client who experiences a significant change in recipient
300 condition or circumstance which results in a change of more than
301 5 percent to his or her cost plan between July 1 and the date
302 that a rebased cost plan would take effect pursuant to this
303 subsection.
304 (7) Nothing in this section or in any administrative rule
305 shall be construed to prevent or limit the Agency for Health
306 Care Administration, in consultation with the Agency for Persons
307 with Disabilities, from adjusting fees, reimbursement rates,
308 lengths of stay, number of visits, or number of services, or

309 from limiting enrollment, or making any other adjustment
310 necessary to comply with the availability of moneys and any
311 limitations or directions provided for in the General
312 Appropriations Act.
313 (8) The Agency for Persons with Disabilities shall submit
314 quarterly status reports to the Executive Office of the
315 Governor, the chair of the Senate Ways and Means Committee or
316 its successor, and the chair of the House Fiscal Council or its
317 successor regarding the financial status of home and community-
318 based services, including the number of enrolled individuals who
319 are receiving services through one or more programs; the number
320 of individuals who have requested services who are not enrolled
321 but who are receiving services through one or more programs,
322 with a description indicating the programs from which the
323 individual is receiving services; the number of individuals who
324 have refused an offer of services but who choose to remain on
325 the list of individuals waiting for services; the number of
326 individuals who have requested services but who are receiving no
327 services; a frequency distribution indicating the length of time
328 individuals have been waiting for services; and information
329 concerning the actual and projected costs compared to the amount
330 of the appropriation available to the program and any projected
331 surpluses or deficits. If at any time an analysis by the agency,
332 in consultation with the Agency for Health Care Administration,
333 indicates that the cost of services is expected to exceed the
334 amount appropriated, the agency shall submit a plan in
335 accordance with subsection (7) to the Executive Office of the
336 Governor, the chair of the Senate Ways and Means Committee or

337 its successor, and the chair of the House Fiscal Council or its
338 successor to remain within the amount appropriated. The agency
339 shall work with the Agency for Health Care Administration to
340 implement the plan so as to remain within the appropriation.
341 (9) The agency shall develop a transition plan for
342 recipients who are receiving services in one of the four waiver
343 tiers at the time eligible managed care plans are available in
344 each recipient's region defined in s. 409.989 to enroll those
345 recipients in eligible plans.
346 (10) This section expires October 1, 2016.
347
348 Section 2. Section 393.0662, Florida Statutes, is amended
349 to read:
350 393.0662 Individual budgets for delivery of home and
351 community-based services; iBudget system established.—The
352 Legislature finds that improved financial management of the
353 existing home and community-based Medicaid waiver program is
354 necessary to avoid deficits that impede the provision of
355 services to individuals who are on the waiting list for
356 enrollment in the program. The Legislature further finds that
357 clients and their families should have greater flexibility to
358 choose the services that best allow them to live in their
359 community within the limits of an established budget. Therefore,
360 the Legislature intends that the agency, in consultation with
361 the Agency for Health Care Administration, develop and implement
362 a comprehensive redesign of the service delivery system using
363 individual budgets as the basis for allocating the funds
364 appropriated for the home and community-based services Medicaid

365 waiver program among eligible enrolled clients. The service
366 delivery system that uses individual budgets shall be called the
367 iBudget system.
368 (1) The agency shall establish an individual budget,
369 referred to as an iBudget, for each individual served by the
370 home and community-based services Medicaid waiver program. The
371 funds appropriated to the agency shall be allocated through the
372 iBudget system to eligible, Medicaid-enrolled clients. The
373 iBudget system shall be designed to provide for: enhanced client
374 choice within a specified service package; appropriate
375 assessment strategies; an efficient consumer budgeting and
376 billing process that includes reconciliation and monitoring
377 components; a redefined role for support coordinators that
378 avoids potential conflicts of interest; a flexible and
379 streamlined service review process; and a methodology and
380 process that ensures the equitable allocation of available funds
381 to each client based on the client's level of need, as
382 determined by the variables in the allocation algorithm.
383 (a) In developing each client's iBudget, the agency shall
384 use an allocation algorithm and methodology. The algorithm shall
385 use variables that have been determined by the agency to have a
386 statistically validated relationship to the client's level of
387 need for services provided through the home and community-based
388 services Medicaid waiver program. The algorithm and methodology
389 may consider individual characteristics, including, but not
390 limited to, a client's age and living situation, information
391 from a formal assessment instrument that the agency determines
392 is valid and reliable, and information from other assessment

393 processes.
394 (b) The allocation methodology shall provide the algorithm
395 that determines the amount of funds allocated to a client's
396 iBudget. The agency may approve an increase in the amount of
397 funds allocated, as determined by the algorithm, based on the
398 client having one or more of the following needs that cannot be
399 accommodated within the funding as determined by the algorithm
400 and having no other resources, supports, or services available
401 to meet the need:
402 1. An extraordinary need that would place the health and
403 safety of the client, the client's caregiver, or the public in
404 immediate, serious jeopardy unless the increase is approved. An
405 extraordinary need may include, but is not limited to:
406 a. A documented history of significant, potentially life-
407 threatening behaviors, such as recent attempts at suicide,
408 arson, nonconsensual sexual behavior, or self-injurious behavior
409 requiring medical attention;
410 b. A complex medical condition that requires active
411 intervention by a licensed nurse on an ongoing basis that cannot
412 be taught or delegated to a nonlicensed person;
413 c. A chronic comorbid condition. As used in this
414 subparagraph, the term "comorbid condition" means a medical
415 condition existing simultaneously but independently with another
416 medical condition in a patient; or
417 d. A need for total physical assistance with activities
418 such as eating, bathing, toileting, grooming, and personal
419 hygiene.
420

421 However, the presence of an extraordinary need alone does not
422 warrant an increase in the amount of funds allocated to a
423 client's iBudget as determined by the algorithm.
424 2. A significant need for one-time or temporary support or
425 services that, if not provided, would place the health and
426 safety of the client, the client's caregiver, or the public in
427 serious jeopardy, unless the increase is approved. A significant
428 need may include, but is not limited to, the provision of
429 environmental modifications, durable medical equipment, services
430 to address the temporary loss of support from a caregiver, or
431 special services or treatment for a serious temporary condition
432 when the service or treatment is expected to ameliorate the
433 underlying condition. As used in this subparagraph, the term
434 "temporary" means a period of fewer than 12 continuous months.
435 However, the presence of such significant need for one-time or
436 temporary supports or services alone does not warrant an
437 increase in the amount of funds allocated to a client's iBudget
438 as determined by the algorithm.
439 3. A significant increase in the need for services after
440 the beginning of the service plan year that would place the
441 health and safety of the client, the client's caregiver, or the
442 public in serious jeopardy because of substantial changes in the
443 client's circumstances, including, but not limited to, permanent
444 or long-term loss or incapacity of a caregiver, loss of services
445 authorized under the state Medicaid plan due to a change in age,
446 or a significant change in medical or functional status which
447 requires the provision of additional services on a permanent or
448 long-term basis that cannot be accommodated within the client's

449 current iBudget. As used in this subparagraph, the term "long-
450 term" means a period of 12 or more continuous months. However,
451 such significant increase in need for services of a permanent or
452 long-term nature alone does not warrant an increase in the
453 amount of funds allocated to a client's iBudget as determined by
454 the algorithm.
455
456 The agency shall reserve portions of the appropriation for the
457 home and community-based services Medicaid waiver program for
458 adjustments required pursuant to this paragraph and may use the
459 services of an independent actuary in determining the amount of
460 the portions to be reserved.
461 (c) A client's iBudget shall be the total of the amount
462 determined by the algorithm and any additional funding provided
463 pursuant to paragraph (b). A client's annual expenditures for
464 home and community-based services Medicaid waiver services may
465 not exceed the limits of his or her iBudget. The total of all
466 clients' projected annual iBudget expenditures may not exceed
467 the agency's appropriation for waiver services.
468 (2) The Agency for Health Care Administration, in
469 consultation with the agency, shall seek federal approval to
470 amend current waivers, request a new waiver, and amend contracts
471 as necessary to implement the iBudget system to serve eligible,
472 enrolled clients through the home and community-based services
473 Medicaid waiver program and the Consumer-Directed Care Plus
474 Program.
475 (3) The agency shall transition all eligible, enrolled
476 clients to the iBudget system. The agency may gradually phase in

477 the iBudget system <u>and must complete the phase in by January 1,</u>
478 <u>2015</u>.
479 (a) While the agency phases in the iBudget system, the
480 agency may continue to serve eligible, enrolled clients under
481 the four-tiered waiver system established under s. 393.065 while
482 those clients await transitioning to the iBudget system.
483 (b) The agency shall design the phase-in process to ensure
484 that a client does not experience more than one-half of any
485 expected overall increase or decrease to his or her existing
486 annualized cost plan during the first year that the client is
487 provided an iBudget due solely to the transition to the iBudget
488 system.
489 (4) A client must use all available services authorized
490 under the state Medicaid plan, school-based services, private
491 insurance and other benefits, and any other resources that may
492 be available to the client before using funds from his or her
493 iBudget to pay for support and services.
494 (5) The service limitations in s. 393.0661(3)(f)1., 2.,
495 and 3. do not apply to the iBudget system.
496 (6) Rates for any or all services established under rules
497 of the Agency for Health Care Administration shall be designated
498 as the maximum rather than a fixed amount for individuals who
499 receive an iBudget, except for services specifically identified
500 in those rules that the agency determines are not appropriate
501 for negotiation, which may include, but are not limited to,
502 residential habilitation services.
503 (7) The agency shall ensure that clients and caregivers
504 have access to training and education to inform them about the

505 iBudget system and enhance their ability for self-direction.
506 Such training shall be offered in a variety of formats and at a
507 minimum shall address the policies and processes of the iBudget
508 system; the roles and responsibilities of consumers, caregivers,
509 waiver support coordinators, providers, and the agency;
510 information available to help the client make decisions
511 regarding the iBudget system; and examples of support and
512 resources available in the community.

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

515 (9) The agency and the Agency for Health Care
516 Administration may adopt rules specifying the allocation
517 algorithm and methodology; criteria and processes for clients to
518 access reserved funds for extraordinary needs, temporarily or
519 permanently changed needs, and one-time needs; and processes and
520 requirements for selection and review of services, development
521 of support and cost plans, and management of the iBudget system
522 as needed to administer this section.

523 (10) The agency shall develop a transition plan for
524 recipients who are receiving services through the ibudget system
525 at the time eligible managed care plans are available in each
526 recipient's region defined in s. 409.989 to enroll those
527 recipients in eligible plans.

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

529 Section 3. Paragraph (b) of subsection (1) of section
530 408.040, Florida Statutes, is amended to read:

531 408.040 Conditions and monitoring.—

532 (1)

533 (b) The agency may consider, in addition to the other
534 criteria specified in s. 408.035, a statement of intent by the
535 applicant that a specified percentage of the annual patient days
536 at the facility will be utilized by patients eligible for care
537 under Title XIX of the Social Security Act. Any certificate of
538 need issued to a nursing home in reliance upon an applicant's
539 statements that a specified percentage of annual patient days
540 will be utilized by residents eligible for care under Title XIX
541 of the Social Security Act must include a statement that such
542 certification is a condition of issuance of the certificate of
543 need. The certificate-of-need program shall notify the Medicaid
544 program office and the Department of Elderly Affairs when it
545 imposes conditions as authorized in this paragraph in an area in
546 which a community diversion pilot project is implemented.
547 Effective July 1, 2012, the agency shall not consider, or impose
548 conditions or sanctions related to, patient day utilization by
549 patients eligible for care under Title XIX the Social Security
550 Act in making certificate-of-need determinations for nursing
551 homes.
552 Section 4. Subsection (1) of section 408.0435, Florida
553 Statutes, is amended to read:
554 408.0435 Moratorium on nursing home certificates of need.—
555 (1) Notwithstanding the establishment of need as provided
556 for in this chapter, a certificate of need for additional
557 community nursing home beds may not be approved by the agency
558 until after Medicaid managed care is implemented statewide
559 pursuant to ss. 409.961-409.992, or October 1, 2016, whichever
560 is earlier ~~July 1, 2011.~~

561 Section 5. Sections 409.016 through 409.803, Florida
562 Statutes, are designated as part I of chapter 409, Florida
563 Statutes, and entitled "SOCIAL AND ECONOMIC ASSISTANCE."
564 Section 6. Sections 409.810 through 409.821, Florida
565 Statutes, are designated as part II of chapter 409, Florida
566 Statutes, and entitled "KIDCARE."
567 Section 7. Sections 409.901 through 409.9205, Florida
568 Statutes, are designated as part III of chapter 409, Florida
569 Statutes, and entitled "MEDICAID."
570 Section 8. Paragraph (c) of subsection (5) of section
571 409.905, Florida Statutes, is amended to read and paragraph (g)
572 of subsection (5) of section 409.905, Florida Statutes, is
573 created to read:
574 409.905 Mandatory Medicaid services.—The agency may make
575 payments for the following services, which are required of the
576 state by Title XIX of the Social Security Act, furnished by
577 Medicaid providers to recipients who are determined to be
578 eligible on the dates on which the services were provided. Any
579 service under this section shall be provided only when medically
580 necessary and in accordance with state and federal law.
581 Mandatory services rendered by providers in mobile units to
582 Medicaid recipients may be restricted by the agency. Nothing in
583 this section shall be construed to prevent or limit the agency
584 from adjusting fees, reimbursement rates, lengths of stay,
585 number of visits, number of services, or any other adjustments
586 necessary to comply with the availability of moneys and any
587 limitations or directions provided for in the General
588 Appropriations Act or chapter 216.

589 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
590 all covered services provided for the medical care and treatment
591 of a recipient who is admitted as an inpatient by a licensed
592 physician or dentist to a hospital licensed under part I of
593 chapter 395. However, the agency shall limit the payment for
594 inpatient hospital services for a Medicaid recipient 21 years of
595 age or older to 45 days or the number of days necessary to
596 comply with the General Appropriations Act.
597 (c) The agency shall implement a methodology for
598 establishing base reimbursements rates for each hospital based
599 on allowable costs, as defined by the agency. Rates shall be
600 calculated annually and become effect at the start of each state
601 fiscal year based on the most recent complete and accurate cost
602 report submitted by each hospital. The rates shall be effective
603 on July 1 of each year. No adjustments will be made to the
604 rates after September 30 of the state fiscal year in which the
605 rate is effective. Errors in cost reporting or calculation of
606 rates discovered after September 30 must be reconciled in a
607 subsequent rate period. Cost reports must be reconciled within
608 five years after the end of the applicable fiscal year.
609 Hospital rates shall be subject to such limits or ceilings as
610 many be established in law or described in the agency's hospital
611 reimbursement plan. Specific exemptions to the limits or
612 ceilings may be provide in the General Appropriations Act.
613 The agency shall adjust a hospital's current inpatient per
614 diem rate to reflect the cost of serving the Medicaid population
615 at that institution if:
616 1. The hospital experiences an increase in Medicaid

617 ~~caseload by more than 25 percent in any year, primarily~~
618 ~~resulting from the closure of a hospital in the same service~~
619 ~~area occurring after July 1, 1995;~~
620 ~~2. The hospital's Medicaid per diem rate is at least 25~~
621 ~~percent below the Medicaid per patient cost for that year; or~~
622 ~~3. The hospital is located in a county that has six or~~
623 ~~fewer general acute care hospitals, began offering obstetrical~~
624 ~~services on or after September 1999, and has submitted a request~~
625 ~~in writing to the agency for a rate adjustment after July 1,~~
626 ~~2000, but before September 30, 2000, in which case such~~
627 ~~hospital's Medicaid inpatient per diem rate shall be adjusted to~~
628 ~~cost, effective July 1, 2002.~~
629
630 ~~By October 1 of each year, the agency must provide estimated~~
631 ~~costs for any adjustment in a hospital inpatient per diem rate~~
632 ~~to the Executive Office of the Governor, the House of~~
633 ~~Representatives General Appropriations Committee, and the Senate~~
634 ~~Appropriations Committee. Before the agency implements a change~~
635 ~~in a hospital's inpatient per diem rate pursuant to this~~
636 ~~paragraph, the Legislature must have specifically appropriated~~
637 ~~sufficient funds in the General Appropriations Act to support~~
638 ~~the increase in cost as estimated by the agency.~~
639 (g) The agency shall develop a plan to convert inpatient
640 hospital rates to a prospective payment system that categorizes
641 each case into diagnosis related groups (DRG) and assigns a
642 payment weight based on the average resources used to treat
643 Medicaid patients in that DRG. To the extent possible, the
644 agency shall propose an adaptation of an existing prospective

645 payment system, such as the one used by Medicare, and shall
646 propose such adjustments as are necessary for the Medicaid
647 population and to maintain budget neutrality for inpatient
648 hospital expenditures. The agency shall submit the Medicaid DRG
649 plan, identifying all steps necessary for the transition and any
650 costs associated with plan implementation, to the Governor, the
651 President of the Senate, and the Speaker of the House of
652 Representatives no later than January 1, 2013.
653 Section 9. Subsection (10) of section 409.911, Florida
654 Statutes, is amended to read:
655 409.911 Disproportionate share program.—Subject to
656 specific allocations established within the General
657 Appropriations Act and any limitations established pursuant to
658 chapter 216, the agency shall distribute, pursuant to this
659 section, moneys to hospitals providing a disproportionate share
660 of Medicaid or charity care services by making quarterly
661 Medicaid payments as required. Notwithstanding the provisions of
662 s. 409.915, counties are exempt from contributing toward the
663 cost of this special reimbursement for hospitals serving a
664 disproportionate share of low-income patients.
665 (10) The Agency for Health Care Administration shall
666 create a Medicaid Low-Income Pool Council by July 1, 2006. The
667 Low-Income Pool Council shall consist of 24 members, including 2
668 members appointed by the President of the Senate, 2 members
669 appointed by the Speaker of the House of Representatives, 3
670 representatives of statutory teaching hospitals, 3
671 representatives of public hospitals, 3 representatives of
672 nonprofit hospitals, 3 representatives of for-profit hospitals,

673 2 representatives of rural hospitals, 2 representatives of units
674 of local government which contribute funding, 1 representative
675 of family practice teaching hospitals, 1 representative of
676 federally qualified health centers, 1 representative from the
677 Department of Health, and 1 nonvoting representative of the
678 Agency for Health Care Administration who shall serve as chair
679 of the council. Except for a full-time employee of a public
680 entity, an individual who qualifies as a lobbyist under s.
681 11.045 or s. 112.3215 may not serve as a member of the council.
682 Of the members appointed by the Senate President, only one shall
683 be a physician. Of the members appointed by the Speaker of the
684 House of Representatives, only one shall be a physician. The
685 physician member appointed by the Senate President and the
686 physician member appointed by the Speaker of the House of
687 Representatives must be physicians who routinely take calls in a
688 trauma center, as defined in s. 395.4001, or a hospital
689 emergency department. The council shall:

690 (a) Make recommendations on the financing of the low-
691 income pool and the disproportionate share hospital program and
692 the distribution of their funds.

693 (b) Advise the Agency for Health Care Administration on
694 the development of the low-income pool plan required by the
695 federal Centers for Medicare and Medicaid Services pursuant to
696 the Medicaid reform waiver.

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

701 (d) Submit its findings and recommendations to the
702 Governor and the Legislature no later than February 1 of each
703 year.
704
705 This subsection expires October 1, 2014.
706 Section 10. Section 409.912, Florida Statutes, is amended
707 to read:
708 409.912 Cost-effective purchasing of health care.—The
709 agency shall purchase goods and services for Medicaid recipients
710 in the most cost-effective manner consistent with the delivery
711 of quality medical care. To ensure that medical services are
712 effectively utilized, the agency may, in any case, require a
713 confirmation or second physician's opinion of the correct
714 diagnosis for purposes of authorizing future services under the
715 Medicaid program. This section does not restrict access to
716 emergency services or poststabilization care services as defined
717 in 42 C.F.R. part 438.114. Such confirmation or second opinion
718 shall be rendered in a manner approved by the agency. The agency
719 shall maximize the use of prepaid per capita and prepaid
720 aggregate fixed-sum basis services when appropriate and other
721 alternative service delivery and reimbursement methodologies,
722 including competitive bidding pursuant to s. 287.057, designed
723 to facilitate the cost-effective purchase of a case-managed
724 continuum of care. The agency shall also require providers to
725 minimize the exposure of recipients to the need for acute
726 inpatient, custodial, and other institutional care and the
727 inappropriate or unnecessary use of high-cost services. The
728 agency shall contract with a vendor to monitor and evaluate the

729 clinical practice patterns of providers in order to identify
730 trends that are outside the normal practice patterns of a
731 provider's professional peers or the national guidelines of a
732 provider's professional association. The vendor must be able to
733 provide information and counseling to a provider whose practice
734 patterns are outside the norms, in consultation with the agency,
735 to improve patient care and reduce inappropriate utilization.
736 The agency may mandate prior authorization, drug therapy
737 management, or disease management participation for certain
738 populations of Medicaid beneficiaries, certain drug classes, or
739 particular drugs to prevent fraud, abuse, overuse, and possible
740 dangerous drug interactions. The Pharmaceutical and Therapeutics
741 Committee shall make recommendations to the agency on drugs for
742 which prior authorization is required. The agency shall inform
743 the Pharmaceutical and Therapeutics Committee of its decisions
744 regarding drugs subject to prior authorization. The agency is
745 authorized to limit the entities it contracts with or enrolls as
746 Medicaid providers by developing a provider network through
747 provider credentialing. The agency may competitively bid single-
748 source-provider contracts if procurement of goods or services
749 results in demonstrated cost savings to the state without
750 limiting access to care. The agency may limit its network based
751 on the assessment of beneficiary access to care, provider
752 availability, provider quality standards, time and distance
753 standards for access to care, the cultural competence of the
754 provider network, demographic characteristics of Medicaid
755 beneficiaries, practice and provider-to-beneficiary standards,
756 appointment wait times, beneficiary use of services, provider

757 turnover, provider profiling, provider licensure history,
758 previous program integrity investigations and findings, peer
759 review, provider Medicaid policy and billing compliance records,
760 clinical and medical record audits, and other factors. Providers
761 shall not be entitled to enrollment in the Medicaid provider
762 network. The agency shall determine instances in which allowing
763 Medicaid beneficiaries to purchase durable medical equipment and
764 other goods is less expensive to the Medicaid program than long-
765 term rental of the equipment or goods. The agency may establish
766 rules to facilitate purchases in lieu of long-term rentals in
767 order to protect against fraud and abuse in the Medicaid program
768 as defined in s. 409.913. The agency may seek federal waivers
769 necessary to administer these policies.
770 (1) The agency shall work with the Department of Children
771 and Family Services to ensure access of children and families in
772 the child protection system to needed and appropriate mental
773 health and substance abuse services. This subsection expires
774 October 1, 2014.
775 (2) The agency may enter into agreements with appropriate
776 agents of other state agencies or of any agency of the Federal
777 Government and accept such duties in respect to social welfare
778 or public aid as may be necessary to implement the provisions of
779 Title XIX of the Social Security Act and ss. 409.901-409.920.
780 This subsection expires October 1, 2016.
781 (3) The agency may contract with health maintenance
782 organizations certified pursuant to part I of chapter 641 for
783 the provision of services to recipients. This subsection
784 expires October 1, 2014.

785 (4) The agency may contract with:
786 (a) An entity that provides no prepaid health care
787 services other than Medicaid services under contract with the
788 agency and which is owned and operated by a county, county
789 health department, or county-owned and operated hospital to
790 provide health care services on a prepaid or fixed-sum basis to
791 recipients, which entity may provide such prepaid services
792 either directly or through arrangements with other providers.
793 Such prepaid health care services entities must be licensed
794 under parts I and III of chapter 641. An entity recognized under
795 this paragraph which demonstrates to the satisfaction of the
796 Office of Insurance Regulation of the Financial Services
797 Commission that it is backed by the full faith and credit of the
798 county in which it is located may be exempted from s. 641.225.
799 This paragraph expires October 1, 2014.
800 (b) An entity that is providing comprehensive behavioral
801 health care services to certain Medicaid recipients through a
802 capitated, prepaid arrangement pursuant to the federal waiver
803 provided for by s. 409.905(5). Such entity must be licensed
804 under chapter 624, chapter 636, or chapter 641, or authorized
805 under paragraph (c) or paragraph (d), and must possess the
806 clinical systems and operational competence to manage risk and
807 provide comprehensive behavioral health care to Medicaid
808 recipients. As used in this paragraph, the term "comprehensive
809 behavioral health care services" means covered mental health and
810 substance abuse treatment services that are available to
811 Medicaid recipients. The secretary of the Department of Children
812 and Family Services shall approve provisions of procurements

813 related to children in the department's care or custody before
814 enrolling such children in a prepaid behavioral health plan. Any
815 contract awarded under this paragraph must be competitively
816 procured. In developing the behavioral health care prepaid plan
817 procurement document, the agency shall ensure that the
818 procurement document requires the contractor to develop and
819 implement a plan to ensure compliance with s. 394.4574 related
820 to services provided to residents of licensed assisted living
821 facilities that hold a limited mental health license. Except as
822 provided in subparagraph 5.~~8.~~, and except in counties where the
823 Medicaid managed care pilot program is authorized pursuant to s.
824 409.91211, the agency shall seek federal approval to contract
825 with a single entity meeting these requirements to provide
826 comprehensive behavioral health care services to all Medicaid
827 recipients not enrolled in a Medicaid managed care plan
828 authorized under s. 409.91211, a provider service network
829 authorized under paragraph (d), or a Medicaid health maintenance
830 organization in an AHCA area. In an AHCA area where the Medicaid
831 managed care pilot program is authorized pursuant to s.
832 409.91211 in one or more counties, the agency may procure a
833 contract with a single entity to serve the remaining counties as
834 an AHCA area or the remaining counties may be included with an
835 adjacent AHCA area and are subject to this paragraph. Each
836 entity must offer a sufficient choice of providers in its
837 network to ensure recipient access to care and the opportunity
838 to select a provider with whom they are satisfied. The network
839 shall include all public mental health hospitals. To ensure
840 unimpaired access to behavioral health care services by Medicaid

841 recipients, all contracts issued pursuant to this paragraph must
842 require 80 percent of the capitation paid to the managed care
843 plan, including health maintenance organizations and capitated
844 provider service networks, to be expended for the provision of
845 behavioral health care services. If the managed care plan
846 expends less than 80 percent of the capitation paid for the
847 provision of behavioral health care services, the difference
848 shall be returned to the agency. The agency shall provide the
849 plan with a certification letter indicating the amount of
850 capitation paid during each calendar year for behavioral health
851 care services pursuant to this section. The agency may reimburse
852 for substance abuse treatment services on a fee-for-service
853 basis until the agency finds that adequate funds are available
854 for capitated, prepaid arrangements.
855 1. ~~By January 1, 2001,~~ The agency shall modify the
856 contracts with the entities providing comprehensive inpatient
857 and outpatient mental health care services to Medicaid
858 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
859 Counties, to include substance abuse treatment services.
860 ~~2. By July 1, 2003, the agency and the Department of~~
861 ~~Children and Family Services shall execute a written agreement~~
862 ~~that requires collaboration and joint development of all policy,~~
863 ~~budgets, procurement documents, contracts, and monitoring plans~~
864 ~~that have an impact on the state and Medicaid community mental~~
865 ~~health and targeted case management programs.~~
866 2. ~~3.~~ Except as provided in subparagraph 5. ~~8.~~, ~~by July 1,~~
867 ~~2006,~~ the agency and the Department of Children and Family
868 Services shall contract with managed care entities in each AHCA

869 area except area 6 or arrange to provide comprehensive inpatient
870 and outpatient mental health and substance abuse services
871 through capitated prepaid arrangements to all Medicaid
872 recipients who are eligible to participate in such plans under
873 federal law and regulation. In AHCA areas where eligible
874 individuals number less than 150,000, the agency shall contract
875 with a single managed care plan to provide comprehensive
876 behavioral health services to all recipients who are not
877 enrolled in a Medicaid health maintenance organization, a
878 provider service network authorized under paragraph (d), or a
879 Medicaid capitated managed care plan authorized under s.
880 409.91211. The agency may contract with more than one
881 comprehensive behavioral health provider to provide care to
882 recipients who are not enrolled in a Medicaid capitated managed
883 care plan authorized under s. 409.91211, a provider service
884 network authorized under paragraph (d), or a Medicaid health
885 maintenance organization in AHCA areas where the eligible
886 population exceeds 150,000. In an AHCA area where the Medicaid
887 managed care pilot program is authorized pursuant to s.
888 409.91211 in one or more counties, the agency may procure a
889 contract with a single entity to serve the remaining counties as
890 an AHCA area or the remaining counties may be included with an
891 adjacent AHCA area and shall be subject to this paragraph.
892 Contracts for comprehensive behavioral health providers awarded
893 pursuant to this section shall be competitively procured. Both
894 for-profit and not-for-profit corporations are eligible to
895 compete. Managed care plans contracting with the agency under
896 subsection (3) or paragraph (d), shall provide and receive

897 payment for the same comprehensive behavioral health benefits as
898 provided in AHCA rules, including handbooks incorporated by
899 reference. In AHCA area 11, the agency shall contract with at
900 least two comprehensive behavioral health care providers to
901 provide behavioral health care to recipients in that area who
902 are enrolled in, or assigned to, the MediPass program. One of
903 the behavioral health care contracts must be with the existing
904 provider service network pilot project, as described in
905 paragraph (d), for the purpose of demonstrating the cost-
906 effectiveness of the provision of quality mental health services
907 through a public hospital-operated managed care model. Payment
908 shall be at an agreed-upon capitated rate to ensure cost
909 savings. Of the recipients in area 11 who are assigned to
910 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
911 MediPass-enrolled recipients shall be assigned to the existing
912 provider service network in area 11 for their behavioral care.
913 ~~4. By October 1, 2003, the agency and the department shall~~
914 ~~submit a plan to the Governor, the President of the Senate, and~~
915 ~~the Speaker of the House of Representatives which provides for~~
916 ~~the full implementation of capitated prepaid behavioral health~~
917 ~~care in all areas of the state.~~
918 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
919 ~~of the state where the agency is able to establish sufficient~~
920 ~~capitation rates.~~
921 ~~b. If the agency determines that the proposed capitation~~
922 ~~rate in any area is insufficient to provide appropriate~~
923 ~~services, the agency may adjust the capitation rate to ensure~~
924 ~~that care will be available. The agency and the department may~~

925 ~~use existing general revenue to address any additional required~~
926 ~~match but may not over-obligate existing funds on an annualized~~
927 ~~basis.~~
928 ~~c. Subject to any limitations provided in the General~~
929 ~~Appropriations Act, the agency, in compliance with appropriate~~
930 ~~federal authorization, shall develop policies and procedures~~
931 ~~that allow for certification of local and state funds.~~
932 3. ~~5.~~ Children residing in a statewide inpatient
933 psychiatric program, or in a Department of Juvenile Justice or a
934 Department of Children and Family Services residential program
935 approved as a Medicaid behavioral health overlay services
936 provider may not be included in a behavioral health care prepaid
937 health plan or any other Medicaid managed care plan pursuant to
938 this paragraph.
939 ~~6. In converting to a prepaid system of delivery, the~~
940 ~~agency shall in its procurement document require an entity~~
941 ~~providing only comprehensive behavioral health care services to~~
942 ~~prevent the displacement of indigent care patients by enrollees~~
943 ~~in the Medicaid prepaid health plan providing behavioral health~~
944 ~~care services from facilities receiving state funding to provide~~
945 ~~indigent behavioral health care, to facilities licensed under~~
946 ~~chapter 395 which do not receive state funding for indigent~~
947 ~~behavioral health care, or reimburse the unsubsidized facility~~
948 ~~for the cost of behavioral health care provided to the displaced~~
949 ~~indigent care patient.~~
950 4. ~~7.~~ Traditional community mental health providers under
951 contract with the Department of Children and Family Services
952 pursuant to part IV of chapter 394, child welfare providers

953 under contract with the Department of Children and Family
954 Services in areas 1 and 6, and inpatient mental health providers
955 licensed pursuant to chapter 395 must be offered an opportunity
956 to accept or decline a contract to participate in any provider
957 network for prepaid behavioral health services.
958 5. ~~8.~~ All Medicaid-eligible children, except children in
959 area 1 and children in Highlands County, Hardee County, Polk
960 County, or Manatee County of area 6, that are open for child
961 welfare services in the HomeSafeNet system, shall receive their
962 behavioral health care services through a specialty prepaid plan
963 operated by community-based lead agencies through a single
964 agency or formal agreements among several agencies. The
965 specialty prepaid plan must result in savings to the state
966 comparable to savings achieved in other Medicaid managed care
967 and prepaid programs. Such plan must provide mechanisms to
968 maximize state and local revenues. The specialty prepaid plan
969 shall be developed by the agency and the Department of Children
970 and Family Services. The agency may seek federal waivers to
971 implement this initiative. Medicaid-eligible children whose
972 cases are open for child welfare services in the HomeSafeNet
973 system and who reside in AHCA area 10 are exempt from the
974 specialty prepaid plan upon the development of a service
975 delivery mechanism for children who reside in area 10 as
976 specified in s. 409.91211(3)(dd).
977
978 This paragraph expires October 1, 2014.
979 (c) A federally qualified health center or an entity owned
980 by one or more federally qualified health centers or an entity

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981 owned by other migrant and community health centers receiving
982 non-Medicaid financial support from the Federal Government to
983 provide health care services on a prepaid or fixed-sum basis to
984 recipients. A federally qualified health center or an entity
985 that is owned by one or more federally qualified health centers
986 and is reimbursed by the agency on a prepaid basis is exempt
987 from parts I and III of chapter 641, but must comply with the
988 solvency requirements in s. 641.2261(2) and meet the appropriate
989 requirements governing financial reserve, quality assurance, and
990 patients' rights established by the agency. This paragraph
991 expires October 1, 2014.
992 (d) 1. A provider service network may be reimbursed on a
993 fee-for-service or prepaid basis. Prepaid provider service
994 networks receive per-member per-month payments. Provider service
995 networks that do not choose to be prepaid plans shall receive
996 fee-for-service rates with a shared savings settlement. The fee-
997 for-service option shall be available to a provider service
998 network only for the first 5 years of the plan's operation or
999 until the contract year beginning October 1, 2014, whichever is
1000 later. The agency shall annually conduct cost reconciliations to
1001 determine the amount of cost savings achieved by fee-for-service
1002 provider service networks for the dates of service in the period
1003 being reconciled. Only payments for covered services for dates
1004 of service within the reconciliation period and paid within 6
1005 months after the last date of service in the reconciliation
1006 period shall be included. The agency shall perform the necessary
1007 adjustments for the inclusion of claims incurred but not
1008 reported within the reconciliation for claims that could be

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1009 received and paid by the agency after the 6-month claims
1010 processing time lag. The agency shall provide the results of the
1011 reconciliations to the fee-for-service provider service networks
1012 within 45 days after the end of the reconciliation period. The
1013 fee-for-service provider service networks shall review and
1014 provide written comments or a letter of concurrence to the
1015 agency within 45 days after receipt of the reconciliation
1016 results. This reconciliation shall be considered final.
1017 2. A provider service network which is reimbursed by the
1018 agency on a prepaid basis shall be exempt from parts I and III
1019 of chapter 641, but must comply with the solvency requirements
1020 in s. 641.2261(2) and meet appropriate financial reserve,
1021 quality assurance, and patient rights requirements as
1022 established by the agency.
1023 3. Medicaid recipients assigned to a provider service
1024 network shall be chosen equally from those who would otherwise
1025 have been assigned to prepaid plans and MediPass. The agency is
1026 authorized to seek federal Medicaid waivers as necessary to
1027 implement the provisions of this section. This subparagraph
1028 expires October 1, 2014. ~~Any contract previously awarded to a~~
1029 ~~provider service network operated by a hospital pursuant to this~~
1030 ~~subsection shall remain in effect for a period of 3 years~~
1031 ~~following the current contract expiration date, regardless of~~
1032 ~~any contractual provisions to the contrary.~~
1033 4. A provider service network is a network established or
1034 organized and operated by a health care provider, or group of
1035 affiliated health care providers, including minority physician
1036 networks and emergency room diversion programs that meet the

1037 requirements of s. 409.91211, which provides a substantial
1038 proportion of the health care items and services under a
1039 contract directly through the provider or affiliated group of
1040 providers and may make arrangements with physicians or other
1041 health care professionals, health care institutions, or any
1042 combination of such individuals or institutions to assume all or
1043 part of the financial risk on a prospective basis for the
1044 provision of basic health services by the physicians, by other
1045 health professionals, or through the institutions. The health
1046 care providers must have a controlling interest in the governing
1047 body of the provider service network organization.
1048 (e) An entity that provides only comprehensive behavioral
1049 health care services to certain Medicaid recipients through an
1050 administrative services organization agreement. Such an entity
1051 must possess the clinical systems and operational competence to
1052 provide comprehensive health care to Medicaid recipients. As
1053 used in this paragraph, the term "comprehensive behavioral
1054 health care services" means covered mental health and substance
1055 abuse treatment services that are available to Medicaid
1056 recipients. Any contract awarded under this paragraph must be
1057 competitively procured. The agency must ensure that Medicaid
1058 recipients have available the choice of at least two managed
1059 care plans for their behavioral health care services. This
1060 paragraph expires October 1, 2014.
1061 ~~(f) An entity that provides in-home physician services to~~
1062 ~~test the cost-effectiveness of enhanced home-based medical care~~
1063 ~~to Medicaid recipients with degenerative neurological diseases~~
1064 ~~and other diseases or disabling conditions associated with high~~

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V

1065 ~~costs to Medicaid. The program shall be designed to serve very~~
1066 ~~disabled persons and to reduce Medicaid reimbursed costs for~~
1067 ~~inpatient, outpatient, and emergency department services. The~~
1068 ~~agency shall contract with vendors on a risk-sharing basis.~~
1069 ~~(g) Children's provider networks that provide care~~
1070 ~~coordination and care management for Medicaid-eligible pediatric~~
1071 ~~patients, primary care, authorization of specialty care, and~~
1072 ~~other urgent and emergency care through organized providers~~
1073 ~~designed to service Medicaid eligibles under age 18 and~~
1074 ~~pediatric emergency departments' diversion programs. The~~
1075 ~~networks shall provide after-hour operations, including evening~~
1076 ~~and weekend hours, to promote, when appropriate, the use of the~~
1077 ~~children's networks rather than hospital emergency departments.~~
1078 (f) ~~(h)~~ An entity authorized in s. 430.205 to contract
1079 with the agency and the Department of Elderly Affairs to provide
1080 health care and social services on a prepaid or fixed-sum basis
1081 to elderly recipients. Such prepaid health care services
1082 entities are exempt from the provisions of part I of chapter 641
1083 for the first 3 years of operation. An entity recognized under
1084 this paragraph that demonstrates to the satisfaction of the
1085 Office of Insurance Regulation that it is backed by the full
1086 faith and credit of one or more counties in which it operates
1087 may be exempted from s. 641.225. This paragraph expires October
1088 1, 2013.
1089 (g) ~~(i)~~ A Children's Medical Services Network, as defined
1090 in s. 391.021. This paragraph expires October 1, 2014.
1091 ~~(5) The Agency for Health Care Administration, in~~
1092 ~~partnership with the Department of Elderly Affairs, shall create~~

1093 ~~an integrated, fixed-payment delivery program for Medicaid~~
1094 ~~recipients who are 60 years of age or older or dually eligible~~
1095 ~~for Medicare and Medicaid. The Agency for Health Care~~
1096 ~~Administration shall implement the integrated program initially~~
1097 ~~on a pilot basis in two areas of the state. The pilot areas~~
1098 ~~shall be Area 7 and Area 11 of the Agency for Health Care~~
1099 ~~Administration. Enrollment in the pilot areas shall be on a~~
1100 ~~voluntary basis and in accordance with approved federal waivers~~
1101 ~~and this section. The agency and its program contractors and~~
1102 ~~providers shall not enroll any individual in the integrated~~
1103 ~~program because the individual or the person legally responsible~~
1104 ~~for the individual fails to choose to enroll in the integrated~~
1105 ~~program. Enrollment in the integrated program shall be~~
1106 ~~exclusively by affirmative choice of the eligible individual or~~
1107 ~~by the person legally responsible for the individual. The~~
1108 ~~integrated program must transfer all Medicaid services for~~
1109 ~~eligible elderly individuals who choose to participate into an~~
1110 ~~integrated-care management model designed to serve Medicaid~~
1111 ~~recipients in the community. The integrated program must combine~~
1112 ~~all funding for Medicaid services provided to individuals who~~
1113 ~~are 60 years of age or older or dually eligible for Medicare and~~
1114 ~~Medicaid into the integrated program, including funds for~~
1115 ~~Medicaid home and community-based waiver services; all Medicaid~~
1116 ~~services authorized in ss. 409.905 and 409.906, excluding funds~~
1117 ~~for Medicaid nursing home services unless the agency is able to~~
1118 ~~demonstrate how the integration of the funds will improve~~
1119 ~~coordinated care for these services in a less costly manner; and~~
1120 ~~Medicare coinsurance and deductibles for persons dually eligible~~

1121 ~~for Medicaid and Medicare as prescribed in s. 409.908(13).~~
1122 ~~(a) Individuals who are 60 years of age or older or dually~~
1123 ~~eligible for Medicare and Medicaid and enrolled in the~~
1124 ~~developmental disabilities waiver program, the family and~~
1125 ~~supported-living waiver program, the project AIDS care waiver~~
1126 ~~program, the traumatic brain injury and spinal cord injury~~
1127 ~~waiver program, the consumer-directed care waiver program, and~~
1128 ~~the program of all-inclusive care for the elderly program, and~~
1129 ~~residents of institutional care facilities for the~~
1130 ~~developmentally disabled, must be excluded from the integrated~~
1131 ~~program.~~
1132 ~~(b) Managed care entities who meet or exceed the agency's~~
1133 ~~minimum standards are eligible to operate the integrated~~
1134 ~~program. Entities eligible to participate include managed care~~
1135 ~~organizations licensed under chapter 641, including entities~~
1136 ~~eligible to participate in the nursing home diversion program,~~
1137 ~~other qualified providers as defined in s. 430.703(7), community~~
1138 ~~care for the elderly lead agencies, and other state-certified~~
1139 ~~community service networks that meet comparable standards as~~
1140 ~~defined by the agency, in consultation with the Department of~~
1141 ~~Elderly Affairs and the Office of Insurance Regulation, to be~~
1142 ~~financially solvent and able to take on financial risk for~~
1143 ~~managed care. Community service networks that are certified~~
1144 ~~pursuant to the comparable standards defined by the agency are~~
1145 ~~not required to be licensed under chapter 641. Managed care~~
1146 ~~entities who operate the integrated program shall be subject to~~
1147 ~~s. 408.7056. Eligible entities shall choose to serve enrollees~~
1148 ~~who are dually eligible for Medicare and Medicaid, enrollees who~~

1149 ~~are 60 years of age or older, or both.~~
1150 ~~(c) The agency must ensure that the capitation-rate-~~
1151 ~~setting methodology for the integrated program is actuarially~~
1152 ~~sound and reflects the intent to provide quality care in the~~
1153 ~~least restrictive setting. The agency must also require~~
1154 ~~integrated-program providers to develop a credentialing system~~
1155 ~~for service providers and to contract with all Gold Seal nursing~~
1156 ~~homes, where feasible, and exclude, where feasible, chronically~~
1157 ~~poor-performing facilities and providers as defined by the~~
1158 ~~agency. The integrated program must develop and maintain an~~
1159 ~~informal provider grievance system that addresses provider~~
1160 ~~payment and contract problems. The agency shall also establish a~~
1161 ~~formal grievance system to address those issues that were not~~
1162 ~~resolved through the informal grievance system. The integrated~~
1163 ~~program must provide that if the recipient resides in a~~
1164 ~~noncontracted residential facility licensed under chapter 400 or~~
1165 ~~chapter 429 at the time of enrollment in the integrated program,~~
1166 ~~the recipient must be permitted to continue to reside in the~~
1167 ~~noncontracted facility as long as the recipient desires. The~~
1168 ~~integrated program must also provide that, in the absence of a~~
1169 ~~contract between the integrated-program provider and the~~
1170 ~~residential facility licensed under chapter 400 or chapter 429,~~
1171 ~~current Medicaid rates must prevail. The integrated-program~~
1172 ~~provider must ensure that electronic nursing home claims that~~
1173 ~~contain sufficient information for processing are paid within 10~~
1174 ~~business days after receipt. Alternately, the integrated-program~~
1175 ~~provider may establish a capitated payment mechanism to~~
1176 ~~prospectively pay nursing homes at the beginning of each month.~~

1177 ~~The agency and the Department of Elderly Affairs must jointly~~
1178 ~~develop procedures to manage the services provided through the~~
1179 ~~integrated program in order to ensure quality and recipient~~
1180 ~~choice.~~
1181 ~~(d) The Office of Program Policy Analysis and Government~~
1182 ~~Accountability, in consultation with the Auditor General, shall~~
1183 ~~comprehensively evaluate the pilot project for the integrated,~~
1184 ~~fixed-payment delivery program for Medicaid recipients created~~
1185 ~~under this subsection. The evaluation shall begin as soon as~~
1186 ~~Medicaid recipients are enrolled in the managed care pilot~~
1187 ~~program plans and shall continue for 24 months thereafter. The~~
1188 ~~evaluation must include assessments of each managed care plan in~~
1189 ~~the integrated program with regard to cost savings; consumer~~
1190 ~~education, choice, and access to services; coordination of care;~~
1191 ~~and quality of care. The evaluation must describe administrative~~
1192 ~~or legal barriers to the implementation and operation of the~~
1193 ~~pilot program and include recommendations regarding statewide~~
1194 ~~expansion of the pilot program. The office shall submit its~~
1195 ~~evaluation report to the Governor, the President of the Senate,~~
1196 ~~and the Speaker of the House of Representatives no later than~~
1197 ~~December 31, 2009.~~
1198 ~~(e) The agency may seek federal waivers or Medicaid state~~
1199 ~~plan amendments and adopt rules as necessary to administer the~~
1200 ~~integrated program. The agency may implement the approved~~
1201 ~~federal waivers and other provisions as specified in this~~
1202 ~~subsection.~~
1203 ~~(f) The implementation of the integrated, fixed-payment~~
1204 ~~delivery program created under this subsection is subject to an~~

1205 ~~appropriation in the General Appropriations Act.~~
1206 (5) ~~(6)~~ The agency may contract with any public or
1207 private entity otherwise authorized by this section on a prepaid
1208 or fixed-sum basis for the provision of health care services to
1209 recipients. An entity may provide prepaid services to
1210 recipients, either directly or through arrangements with other
1211 entities, if each entity involved in providing services:
1212 (a) Is organized primarily for the purpose of providing
1213 health care or other services of the type regularly offered to
1214 Medicaid recipients;
1215 (b) Ensures that services meet the standards set by the
1216 agency for quality, appropriateness, and timeliness;
1217 (c) Makes provisions satisfactory to the agency for
1218 insolvency protection and ensures that neither enrolled Medicaid
1219 recipients nor the agency will be liable for the debts of the
1220 entity;
1221 (d) Submits to the agency, if a private entity, a
1222 financial plan that the agency finds to be fiscally sound and
1223 that provides for working capital in the form of cash or
1224 equivalent liquid assets excluding revenues from Medicaid
1225 premium payments equal to at least the first 3 months of
1226 operating expenses or $200,000, whichever is greater;
1227 (e) Furnishes evidence satisfactory to the agency of
1228 adequate liability insurance coverage or an adequate plan of
1229 self-insurance to respond to claims for injuries arising out of
1230 the furnishing of health care;
1231 (f) Provides, through contract or otherwise, for periodic
1232 review of its medical facilities and services, as required by

1233 the agency; and
1234 (g) Provides organizational, operational, financial, and
1235 other information required by the agency.
1236
1237 <u>This subsection expires October 1, 2014.</u>
1238
1239 <u>(6)</u> ~~(7)~~ The agency may contract on a prepaid or fixed-sum
1240 basis with any health insurer that:
1241 (a) Pays for health care services provided to enrolled
1242 Medicaid recipients in exchange for a premium payment paid by
1243 the agency;
1244 (b) Assumes the underwriting risk; and
1245 (c) Is organized and licensed under applicable provisions
1246 of the Florida Insurance Code and is currently in good standing
1247 with the Office of Insurance Regulation.
1248
1249 <u>This subsection expires October 1, 2014.</u>
1250
1251 <u>(7)</u> ~~(8)(a)~~ The agency may contract on a prepaid or fixed-
1252 sum basis with an exclusive provider organization to provide
1253 health care services to Medicaid recipients provided that the
1254 exclusive provider organization meets applicable managed care
1255 plan requirements in this section, ss. 409.9122, 409.9123,
1256 409.9128, and 627.6472, and other applicable provisions of law.
1257 <u>This subsection expires October 1, 2014.</u>
1258 ~~(b) For a period of no longer than 24 months after the~~
1259 ~~effective date of this paragraph, when a member of an exclusive~~
1260 ~~provider organization that is contracted by the agency to~~

1261 ~~provide health care services to Medicaid recipients in rural~~
1262 ~~areas without a health maintenance organization obtains services~~
1263 ~~from a provider that participates in the Medicaid program in~~
1264 ~~this state, the provider shall be paid in accordance with the~~
1265 ~~appropriate fee schedule for services provided to eligible~~
1266 ~~Medicaid recipients. The agency may seek waiver authority to~~
1267 ~~implement this paragraph.~~
1268 (8) ~~(9)~~ The Agency for Health Care Administration may
1269 provide cost-effective purchasing of chiropractic services on a
1270 fee-for-service basis to Medicaid recipients through
1271 arrangements with a statewide chiropractic preferred provider
1272 organization incorporated in this state as a not-for-profit
1273 corporation. The agency shall ensure that the benefit limits and
1274 prior authorization requirements in the current Medicaid program
1275 shall apply to the services provided by the chiropractic
1276 preferred provider organization. This subsection expires October
1277 1, 2014.
1278 (9) ~~(10)~~ The agency shall not contract on a prepaid or
1279 fixed-sum basis for Medicaid services with an entity which knows
1280 or reasonably should know that any officer, director, agent,
1281 managing employee, or owner of stock or beneficial interest in
1282 excess of 5 percent common or preferred stock, or the entity
1283 itself, has been found guilty of, regardless of adjudication, or
1284 entered a plea of nolo contendere, or guilty, to:
1285 (a) Fraud;
1286 (b) Violation of federal or state antitrust statutes,
1287 including those proscribing price fixing between competitors and
1288 the allocation of customers among competitors;

1289 (c) Commission of a felony involving embezzlement, theft,
1290 forgery, income tax evasion, bribery, falsification or
1291 destruction of records, making false statements, receiving
1292 stolen property, making false claims, or obstruction of justice;
1293 or
1294 (d) Any crime in any jurisdiction which directly relates
1295 to the provision of health services on a prepaid or fixed-sum
1296 basis.
1297
1298 This subsection expires October 1, 2014.
1299
1300 (10) ~~(11)~~ The agency, after notifying the Legislature, may
1301 apply for waivers of applicable federal laws and regulations as
1302 necessary to implement more appropriate systems of health care
1303 for Medicaid recipients and reduce the cost of the Medicaid
1304 program to the state and federal governments and shall implement
1305 such programs, after legislative approval, within a reasonable
1306 period of time after federal approval. These programs must be
1307 designed primarily to reduce the need for inpatient care,
1308 custodial care and other long-term or institutional care, and
1309 other high-cost services. Prior to seeking legislative approval
1310 of such a waiver as authorized by this subsection, the agency
1311 shall provide notice and an opportunity for public comment.
1312 Notice shall be provided to all persons who have made requests
1313 of the agency for advance notice and shall be published in the
1314 Florida Administrative Weekly not less than 28 days prior to the
1315 intended action. This subsection expires October 1, 2016.
1316 (11) ~~(12)~~ The agency shall establish a postpayment

1317 utilization control program designed to identify recipients who
1318 may inappropriately overuse or underuse Medicaid services and
1319 shall provide methods to correct such misuse. This subsection
1320 expires October 1, 2014.
1321 (12) ~~(13)~~ The agency shall develop and provide coordinated
1322 systems of care for Medicaid recipients and may contract with
1323 public or private entities to develop and administer such
1324 systems of care among public and private health care providers
1325 in a given geographic area. This subsection expires October 1,
1326 2014.
1327 (13) ~~(14)(a)~~ The agency shall operate or contract for the
1328 operation of utilization management and incentive systems
1329 designed to encourage cost-effective use of services and to
1330 eliminate services that are medically unnecessary. The agency
1331 shall track Medicaid provider prescription and billing patterns
1332 and evaluate them against Medicaid medical necessity criteria
1333 and coverage and limitation guidelines adopted by rule. Medical
1334 necessity determination requires that service be consistent with
1335 symptoms or confirmed diagnosis of illness or injury under
1336 treatment and not in excess of the patient's needs. The agency
1337 shall conduct reviews of provider exceptions to peer group norms
1338 and shall, using statistical methodologies, provider profiling,
1339 and analysis of billing patterns, detect and investigate
1340 abnormal or unusual increases in billing or payment of claims
1341 for Medicaid services and medically unnecessary provision of
1342 services. Providers that demonstrate a pattern of submitting
1343 claims for medically unnecessary services shall be referred to
1344 the Medicaid program integrity unit for investigation. In its

1345 annual report, required in s. 409.913, the agency shall report
1346 on its efforts to control overutilization as described in this
1347 subsection ~~paragraph~~. This subsection expires October 1, 2014.
1348 ~~(b) The agency shall develop a procedure for determining~~
1349 ~~whether health care providers and service vendors can provide~~
1350 ~~the Medicaid program using a business case that demonstrates~~
1351 ~~whether a particular good or service can offset the cost of~~
1352 ~~providing the good or service in an alternative setting or~~
1353 ~~through other means and therefore should receive a higher~~
1354 ~~reimbursement. The business case must include, but need not be~~
1355 ~~limited to:~~
1356 ~~1. A detailed description of the good or service to be~~
1357 ~~provided, a description and analysis of the agency's current~~
1358 ~~performance of the service, and a rationale documenting how~~
1359 ~~providing the service in an alternative setting would be in the~~
1360 ~~best interest of the state, the agency, and its clients.~~
1361 ~~2. A cost-benefit analysis documenting the estimated~~
1362 ~~specific direct and indirect costs, savings, performance~~
1363 ~~improvements, risks, and qualitative and quantitative benefits~~
1364 ~~involved in or resulting from providing the service. The cost-~~
1365 ~~benefit analysis must include a detailed plan and timeline~~
1366 ~~identifying all actions that must be implemented to realize~~
1367 ~~expected benefits. The Secretary of Health Care Administration~~
1368 ~~shall verify that all costs, savings, and benefits are valid and~~
1369 ~~achievable.~~
1370 ~~(c) If the agency determines that the increased~~
1371 ~~reimbursement is cost-effective, the agency shall recommend a~~
1372 ~~change in the reimbursement schedule for that particular good or~~

1373 ~~service. If, within 12 months after implementing any rate change~~
1374 ~~under this procedure, the agency determines that costs were not~~
1375 ~~offset by the increased reimbursement schedule, the agency may~~
1376 ~~revert to the former reimbursement schedule for the particular~~
1377 ~~good or service.~~
1378 (14) ~~(15)~~(a) The agency shall operate the Comprehensive
1379 Assessment and Review for Long-Term Care Services (CARES)
1380 nursing facility preadmission screening program to ensure that
1381 Medicaid payment for nursing facility care is made only for
1382 individuals whose conditions require such care and to ensure
1383 that long-term care services are provided in the setting most
1384 appropriate to the needs of the person and in the most
1385 economical manner possible. The CARES program shall also ensure
1386 that individuals participating in Medicaid home and community-
1387 based waiver programs meet criteria for those programs,
1388 consistent with approved federal waivers.
1389 (b) The agency shall operate the CARES program through an
1390 interagency agreement with the Department of Elderly Affairs.
1391 The agency, in consultation with the Department of Elderly
1392 Affairs, may contract for any function or activity of the CARES
1393 program, including any function or activity required by 42
1394 C.F.R. part 483.20, relating to preadmission screening and
1395 resident review.
1396 (c) Prior to making payment for nursing facility services
1397 for a Medicaid recipient, the agency must verify that the
1398 nursing facility preadmission screening program has determined
1399 that the individual requires nursing facility care and that the
1400 individual cannot be safely served in community-based programs.

1401 The nursing facility preadmission screening program shall refer
1402 a Medicaid recipient to a community-based program if the
1403 individual could be safely served at a lower cost and the
1404 recipient chooses to participate in such program. For
1405 individuals whose nursing home stay is initially funded by
1406 Medicare and Medicare coverage is being terminated for lack of
1407 progress towards rehabilitation, CARES staff shall consult with
1408 the person making the determination of progress toward
1409 rehabilitation to ensure that the recipient is not being
1410 inappropriately disqualified from Medicare coverage. If, in
1411 their professional judgment, CARES staff believes that a
1412 Medicare beneficiary is still making progress toward
1413 rehabilitation, they may assist the Medicare beneficiary with an
1414 appeal of the disqualification from Medicare coverage. The use
1415 of CARES teams to review Medicare denials for coverage under
1416 this section is authorized only if it is determined that such
1417 reviews qualify for federal matching funds through Medicaid. The
1418 agency shall seek or amend federal waivers as necessary to
1419 implement this section.
1420 (d) For the purpose of initiating immediate prescreening
1421 and diversion assistance for individuals residing in nursing
1422 homes and in order to make families aware of alternative long-
1423 term care resources so that they may choose a more cost-
1424 effective setting for long-term placement, CARES staff shall
1425 conduct an assessment and review of a sample of individuals
1426 whose nursing home stay is expected to exceed 20 days,
1427 regardless of the initial funding source for the nursing home
1428 placement. CARES staff shall provide counseling and referral

1429 services to these individuals regarding choosing appropriate
1430 long-term care alternatives. This paragraph does not apply to
1431 continuing care facilities licensed under chapter 651 or to
1432 retirement communities that provide a combination of nursing
1433 home, independent living, and other long-term care services.
1434 (e) By January 15 of each year, the agency shall submit a
1435 report to the Legislature describing the operations of the CARES
1436 program. The report must describe:
1437 1. Rate of diversion to community alternative programs;
1438 2. CARES program staffing needs to achieve additional
1439 diversions;
1440 3. Reasons the program is unable to place individuals in
1441 less restrictive settings when such individuals desired such
1442 services and could have been served in such settings;
1443 4. Barriers to appropriate placement, including barriers
1444 due to policies or operations of other agencies or state-funded
1445 programs; and
1446 5. Statutory changes necessary to ensure that individuals
1447 in need of long-term care services receive care in the least
1448 restrictive environment.
1449 (f) The Department of Elderly Affairs shall track
1450 individuals over time who are assessed under the CARES program
1451 and who are diverted from nursing home placement. By January 15
1452 of each year, the department shall submit to the Legislature a
1453 longitudinal study of the individuals who are diverted from
1454 nursing home placement. The study must include:
1455 1. The demographic characteristics of the individuals
1456 assessed and diverted from nursing home placement, including,

1457 but not limited to, age, race, gender, frailty, caregiver
1458 status, living arrangements, and geographic location;
1459 2. A summary of community services provided to individuals
1460 for 1 year after assessment and diversion;
1461 3. A summary of inpatient hospital admissions for
1462 individuals who have been diverted; and
1463 4. A summary of the length of time between diversion and
1464 subsequent entry into a nursing home or death.
1465
1466 This subsection expires October 1, 2013.
1467 (15) ~~(16)~~(a) The agency shall identify health care
1468 utilization and price patterns within the Medicaid program which
1469 are not cost-effective or medically appropriate and assess the
1470 effectiveness of new or alternate methods of providing and
1471 monitoring service, and may implement such methods as it
1472 considers appropriate. Such methods may include disease
1473 management initiatives, an integrated and systematic approach
1474 for managing the health care needs of recipients who are at risk
1475 of or diagnosed with a specific disease by using best practices,
1476 prevention strategies, clinical-practice improvement, clinical
1477 interventions and protocols, outcomes research, information
1478 technology, and other tools and resources to reduce overall
1479 costs and improve measurable outcomes.
1480 (b) The responsibility of the agency under this subsection
1481 shall include the development of capabilities to identify actual
1482 and optimal practice patterns; patient and provider educational
1483 initiatives; methods for determining patient compliance with
1484 prescribed treatments; fraud, waste, and abuse prevention and

1485 detection programs; and beneficiary case management programs.
1486 1. The practice pattern identification program shall
1487 evaluate practitioner prescribing patterns based on national and
1488 regional practice guidelines, comparing practitioners to their
1489 peer groups. The agency and its Drug Utilization Review Board
1490 shall consult with the Department of Health and a panel of
1491 practicing health care professionals consisting of the
1492 following: the Speaker of the House of Representatives and the
1493 President of the Senate shall each appoint three physicians
1494 licensed under chapter 458 or chapter 459; and the Governor
1495 shall appoint two pharmacists licensed under chapter 465 and one
1496 dentist licensed under chapter 466 who is an oral surgeon. Terms
1497 of the panel members shall expire at the discretion of the
1498 appointing official. The advisory panel shall be responsible for
1499 evaluating treatment guidelines and recommending ways to
1500 incorporate their use in the practice pattern identification
1501 program. Practitioners who are prescribing inappropriately or
1502 inefficiently, as determined by the agency, may have their
1503 prescribing of certain drugs subject to prior authorization or
1504 may be terminated from all participation in the Medicaid
1505 program.
1506 2. The agency shall also develop educational interventions
1507 designed to promote the proper use of medications by providers
1508 and beneficiaries.
1509 3. The agency shall implement a pharmacy fraud, waste, and
1510 abuse initiative that may include a surety bond or letter of
1511 credit requirement for participating pharmacies, enhanced
1512 provider auditing practices, the use of additional fraud and

1513 abuse software, recipient management programs for beneficiaries
1514 inappropriately using their benefits, and other steps that will
1515 eliminate provider and recipient fraud, waste, and abuse. The
1516 initiative shall address enforcement efforts to reduce the
1517 number and use of counterfeit prescriptions.
1518 4. By September 30, 2002, the agency shall contract with
1519 an entity in the state to implement a wireless handheld clinical
1520 pharmacology drug information database for practitioners. The
1521 initiative shall be designed to enhance the agency's efforts to
1522 reduce fraud, abuse, and errors in the prescription drug benefit
1523 program and to otherwise further the intent of this paragraph.
1524 5. By April 1, 2006, the agency shall contract with an
1525 entity to design a database of clinical utilization information
1526 or electronic medical records for Medicaid providers. This
1527 system must be web-based and allow providers to review on a
1528 real-time basis the utilization of Medicaid services, including,
1529 but not limited to, physician office visits, inpatient and
1530 outpatient hospitalizations, laboratory and pathology services,
1531 radiological and other imaging services, dental care, and
1532 patterns of dispensing prescription drugs in order to coordinate
1533 care and identify potential fraud and abuse.
1534 6. The agency may apply for any federal waivers needed to
1535 administer this paragraph.
1536
1537 This subsection expires October 1, 2014.
1538 (16) ~~(17)~~ An entity contracting on a prepaid or fixed-sum
1539 basis shall meet the surplus requirements of s. 641.225. If an
1540 entity's surplus falls below an amount equal to the surplus

1541 requirements of s. 641.225, the agency shall prohibit the entity
1542 from engaging in marketing and preenrollment activities, shall
1543 cease to process new enrollments, and may not renew the entity's
1544 contract until the required balance is achieved. The
1545 requirements of this subsection do not apply:
1546 (a) Where a public entity agrees to fund any deficit
1547 incurred by the contracting entity; or
1548 (b) Where the entity's performance and obligations are
1549 guaranteed in writing by a guaranteeing organization which:
1550 1. Has been in operation for at least 5 years and has
1551 assets in excess of $50 million; or
1552 2. Submits a written guarantee acceptable to the agency
1553 which is irrevocable during the term of the contracting entity's
1554 contract with the agency and, upon termination of the contract,
1555 until the agency receives proof of satisfaction of all
1556 outstanding obligations incurred under the contract.
1557
1558 This subsection expires October 1, 2014.
1559 (17) ~~(18)~~ (a) The agency may require an entity contracting
1560 on a prepaid or fixed-sum basis to establish a restricted
1561 insolvency protection account with a federally guaranteed
1562 financial institution licensed to do business in this state. The
1563 entity shall deposit into that account 5 percent of the
1564 capitation payments made by the agency each month until a
1565 maximum total of 2 percent of the total current contract amount
1566 is reached. The restricted insolvency protection account may be
1567 drawn upon with the authorized signatures of two persons
1568 designated by the entity and two representatives of the agency.

1569 If the agency finds that the entity is insolvent, the agency may
1570 draw upon the account solely with the two authorized signatures
1571 of representatives of the agency, and the funds may be disbursed
1572 to meet financial obligations incurred by the entity under the
1573 prepaid contract. If the contract is terminated, expired, or not
1574 continued, the account balance must be released by the agency to
1575 the entity upon receipt of proof of satisfaction of all
1576 outstanding obligations incurred under this contract.
1577 (b) The agency may waive the insolvency protection account
1578 requirement in writing when evidence is on file with the agency
1579 of adequate insolvency insurance and reinsurance that will
1580 protect enrollees if the entity becomes unable to meet its
1581 obligations.
1582
1583 This subsection expires October 1, 2014.
1584 (18) ~~(19)~~ An entity that contracts with the agency on a
1585 prepaid or fixed-sum basis for the provision of Medicaid
1586 services shall reimburse any hospital or physician that is
1587 outside the entity's authorized geographic service area as
1588 specified in its contract with the agency, and that provides
1589 services authorized by the entity to its members, at a rate
1590 negotiated with the hospital or physician for the provision of
1591 services or according to the lesser of the following:
1592 (a) The usual and customary charges made to the general
1593 public by the hospital or physician; or
1594 (b) The Florida Medicaid reimbursement rate established
1595 for the hospital or physician.
1596

1597 This subsection expires October 1, 2014.
1598 (19) ~~(20)~~ When a merger or acquisition of a Medicaid
1599 prepaid contractor has been approved by the Office of Insurance
1600 Regulation pursuant to s. 628.4615, the agency shall approve the
1601 assignment or transfer of the appropriate Medicaid prepaid
1602 contract upon request of the surviving entity of the merger or
1603 acquisition if the contractor and the other entity have been in
1604 good standing with the agency for the most recent 12-month
1605 period, unless the agency determines that the assignment or
1606 transfer would be detrimental to the Medicaid recipients or the
1607 Medicaid program. To be in good standing, an entity must not
1608 have failed accreditation or committed any material violation of
1609 the requirements of s. 641.52 and must meet the Medicaid
1610 contract requirements. For purposes of this section, a merger or
1611 acquisition means a change in controlling interest of an entity,
1612 including an asset or stock purchase. This subsection expires
1613 October 1, 2014.
1614 (20) ~~(21)~~ Any entity contracting with the agency pursuant
1615 to this section to provide health care services to Medicaid
1616 recipients is prohibited from engaging in any of the following
1617 practices or activities:
1618 (a) Practices that are discriminatory, including, but not
1619 limited to, attempts to discourage participation on the basis of
1620 actual or perceived health status.
1621 (b) Activities that could mislead or confuse recipients,
1622 or misrepresent the organization, its marketing representatives,
1623 or the agency. Violations of this paragraph include, but are not
1624 limited to:

1625 1. False or misleading claims that marketing
1626 representatives are employees or representatives of the state or
1627 county, or of anyone other than the entity or the organization
1628 by whom they are reimbursed.
1629 2. False or misleading claims that the entity is
1630 recommended or endorsed by any state or county agency, or by any
1631 other organization which has not certified its endorsement in
1632 writing to the entity.
1633 3. False or misleading claims that the state or county
1634 recommends that a Medicaid recipient enroll with an entity.
1635 4. Claims that a Medicaid recipient will lose benefits
1636 under the Medicaid program, or any other health or welfare
1637 benefits to which the recipient is legally entitled, if the
1638 recipient does not enroll with the entity.
1639 (c) Granting or offering of any monetary or other valuable
1640 consideration for enrollment, except as authorized by subsection
1641 (23) ~~(24)~~.
1642 (d) Door-to-door solicitation of recipients who have not
1643 contacted the entity or who have not invited the entity to make
1644 a presentation.
1645 (e) Solicitation of Medicaid recipients by marketing
1646 representatives stationed in state offices unless approved and
1647 supervised by the agency or its agent and approved by the
1648 affected state agency when solicitation occurs in an office of
1649 the state agency. The agency shall ensure that marketing
1650 representatives stationed in state offices shall market their
1651 managed care plans to Medicaid recipients only in designated
1652 areas and in such a way as to not interfere with the recipients'

1653 activities in the state office.
1654 (f) Enrollment of Medicaid recipients.
1655
1656 This subsection expires October 1, 2014.
1657 (21) ~~(22)~~ The agency may impose a fine for a violation of
1658 this section or the contract with the agency by a person or
1659 entity that is under contract with the agency. With respect to
1660 any nonwillful violation, such fine shall not exceed $2,500 per
1661 violation. In no event shall such fine exceed an aggregate
1662 amount of $10,000 for all nonwillful violations arising out of
1663 the same action. With respect to any knowing and willful
1664 violation of this section or the contract with the agency, the
1665 agency may impose a fine upon the entity in an amount not to
1666 exceed $20,000 for each such violation. In no event shall such
1667 fine exceed an aggregate amount of $100,000 for all knowing and
1668 willful violations arising out of the same action. This
1669 subsection expires October 1, 2014.
1670 (22) ~~(23)~~ A health maintenance organization or a person or
1671 entity exempt from chapter 641 that is under contract with the
1672 agency for the provision of health care services to Medicaid
1673 recipients may not use or distribute marketing materials used to
1674 solicit Medicaid recipients, unless such materials have been
1675 approved by the agency. The provisions of this subsection do not
1676 apply to general advertising and marketing materials used by a
1677 health maintenance organization to solicit both non-Medicaid
1678 subscribers and Medicaid recipients. This subsection expires
1679 October 1, 2014.
1680 (23) ~~(24)~~ Upon approval by the agency, health maintenance

1681 organizations and persons or entities exempt from chapter 641
1682 that are under contract with the agency for the provision of
1683 health care services to Medicaid recipients may be permitted
1684 within the capitation rate to provide additional health benefits
1685 that the agency has found are of high quality, are practicably
1686 available, provide reasonable value to the recipient, and are
1687 provided at no additional cost to the state. This subsection
1688 expires October 1, 2014.
1689 (24) ~~(25)~~ The agency shall utilize the statewide health
1690 maintenance organization complaint hotline for the purpose of
1691 investigating and resolving Medicaid and prepaid health plan
1692 complaints, maintaining a record of complaints and confirmed
1693 problems, and receiving disenrollment requests made by
1694 recipients. This subsection expires October 1, 2014.
1695 (25) ~~(26)~~ The agency shall require the publication of the
1696 health maintenance organization's and the prepaid health plan's
1697 consumer services telephone numbers and the "800" telephone
1698 number of the statewide health maintenance organization
1699 complaint hotline on each Medicaid identification card issued by
1700 a health maintenance organization or prepaid health plan
1701 contracting with the agency to serve Medicaid recipients and on
1702 each subscriber handbook issued to a Medicaid recipient. This
1703 subsection expires October 1, 2014.
1704
1705 (26) ~~(27)~~ The agency shall establish a health care quality
1706 improvement system for those entities contracting with the
1707 agency pursuant to this section, incorporating all the standards
1708 and guidelines developed by the Medicaid Bureau of the Health

1709 Care Financing Administration as a part of the quality assurance
1710 reform initiative. The system shall include, but need not be
1711 limited to, the following:
1712 (a) Guidelines for internal quality assurance programs,
1713 including standards for:
1714 1. Written quality assurance program descriptions.
1715 2. Responsibilities of the governing body for monitoring,
1716 evaluating, and making improvements to care.
1717 3. An active quality assurance committee.
1718 4. Quality assurance program supervision.
1719 5. Requiring the program to have adequate resources to
1720 effectively carry out its specified activities.
1721 6. Provider participation in the quality assurance
1722 program.
1723 7. Delegation of quality assurance program activities.
1724 8. Credentialing and recredentialing.
1725 9. Enrollee rights and responsibilities.
1726 10. Availability and accessibility to services and care.
1727 11. Ambulatory care facilities.
1728 12. Accessibility and availability of medical records, as
1729 well as proper recordkeeping and process for record review.
1730 13. Utilization review.
1731 14. A continuity of care system.
1732 15. Quality assurance program documentation.
1733 16. Coordination of quality assurance activity with other
1734 management activity.
1735 17. Delivering care to pregnant women and infants; to
1736 elderly and disabled recipients, especially those who are at

1737 risk of institutional placement; to persons with developmental
1738 disabilities; and to adults who have chronic, high-cost medical
1739 conditions.
1740 (b) Guidelines which require the entities to conduct
1741 quality-of-care studies which:
1742 1. Target specific conditions and specific health service
1743 delivery issues for focused monitoring and evaluation.
1744 2. Use clinical care standards or practice guidelines to
1745 objectively evaluate the care the entity delivers or fails to
1746 deliver for the targeted clinical conditions and health services
1747 delivery issues.
1748 3. Use quality indicators derived from the clinical care
1749 standards or practice guidelines to screen and monitor care and
1750 services delivered.
1751 (c) Guidelines for external quality review of each
1752 contractor which require: focused studies of patterns of care;
1753 individual care review in specific situations; and followup
1754 activities on previous pattern-of-care study findings and
1755 individual-care-review findings. In designing the external
1756 quality review function and determining how it is to operate as
1757 part of the state's overall quality improvement system, the
1758 agency shall construct its external quality review organization
1759 and entity contracts to address each of the following:
1760 1. Delineating the role of the external quality review
1761 organization.
1762 2. Length of the external quality review organization
1763 contract with the state.
1764 3. Participation of the contracting entities in designing

1765 external quality review organization review activities.
1766 4. Potential variation in the type of clinical conditions
1767 and health services delivery issues to be studied at each plan.
1768 5. Determining the number of focused pattern-of-care
1769 studies to be conducted for each plan.
1770 6. Methods for implementing focused studies.
1771 7. Individual care review.
1772 8. Followup activities.
1773
1774 This subsection expires October 1, 2016.
1775 (27) ~~(28)~~ In order to ensure that children receive health
1776 care services for which an entity has already been compensated,
1777 an entity contracting with the agency pursuant to this section
1778 shall achieve an annual Early and Periodic Screening, Diagnosis,
1779 and Treatment (EPSDT) Service screening rate of at least 60
1780 percent for those recipients continuously enrolled for at least
1781 8 months. The agency shall develop a method by which the EPSDT
1782 screening rate shall be calculated. For any entity which does
1783 not achieve the annual 60 percent rate, the entity must submit a
1784 corrective action plan for the agency's approval. If the entity
1785 does not meet the standard established in the corrective action
1786 plan during the specified timeframe, the agency is authorized to
1787 impose appropriate contract sanctions. At least annually, the
1788 agency shall publicly release the EPSDT Services screening rates
1789 of each entity it has contracted with on a prepaid basis to
1790 serve Medicaid recipients. This subsection expires October 1,
1791 2014.
1792 (28) ~~(29)~~ The agency shall perform enrollments and

1793 disenrollments for Medicaid recipients who are eligible for
1794 MediPass or managed care plans. Notwithstanding the prohibition
1795 contained in paragraph (21)(f), managed care plans may perform
1796 preenrollments of Medicaid recipients under the supervision of
1797 the agency or its agents. For the purposes of this section, the
1798 term "preenrollment" means the provision of marketing and
1799 educational materials to a Medicaid recipient and assistance in
1800 completing the application forms, but does not include actual
1801 enrollment into a managed care plan. An application for
1802 enrollment may not be deemed complete until the agency or its
1803 agent verifies that the recipient made an informed, voluntary
1804 choice. The agency, in cooperation with the Department of
1805 Children and Family Services, may test new marketing initiatives
1806 to inform Medicaid recipients about their managed care options
1807 at selected sites. The agency may contract with a third party to
1808 perform managed care plan and MediPass enrollment and
1809 disenrollment services for Medicaid recipients and may adopt
1810 rules to administer such services. The agency may adjust the
1811 capitation rate only to cover the costs of a third-party
1812 enrollment and disenrollment contract, and for agency
1813 supervision and management of the managed care plan enrollment
1814 and disenrollment contract. This subsection expires October 1,
1815 2014.
1816 (29) ~~(30)~~ Any lists of providers made available to
1817 Medicaid recipients, MediPass enrollees, or managed care plan
1818 enrollees shall be arranged alphabetically showing the
1819 provider's name and specialty and, separately, by specialty in
1820 alphabetical order. This subsection expires October 1, 2014.

1821 (30) ~~(31)~~ The agency shall establish an enhanced managed
1822 care quality assurance oversight function, to include at least
1823 the following components:
1824 (a) At least quarterly analysis and followup, including
1825 sanctions as appropriate, of managed care participant
1826 utilization of services.
1827 (b) At least quarterly analysis and followup, including
1828 sanctions as appropriate, of quality findings of the Medicaid
1829 peer review organization and other external quality assurance
1830 programs.
1831 (c) At least quarterly analysis and followup, including
1832 sanctions as appropriate, of the fiscal viability of managed
1833 care plans.
1834 (d) At least quarterly analysis and followup, including
1835 sanctions as appropriate, of managed care participant
1836 satisfaction and disenrollment surveys.
1837 (e) The agency shall conduct regular and ongoing Medicaid
1838 recipient satisfaction surveys.
1839
1840 The analyses and followup activities conducted by the agency
1841 under its enhanced managed care quality assurance oversight
1842 function shall not duplicate the activities of accreditation
1843 reviewers for entities regulated under part III of chapter 641,
1844 but may include a review of the finding of such reviewers. This
1845 subsection expires October 1, 2014.
1846 (31) ~~(32)~~ Each managed care plan that is under contract
1847 with the agency to provide health care services to Medicaid
1848 recipients shall annually conduct a background check with the

1849 Department of Law Enforcement of all persons with ownership
1850 interest of 5 percent or more or executive management
1851 responsibility for the managed care plan and shall submit to the
1852 agency information concerning any such person who has been found
1853 guilty of, regardless of adjudication, or has entered a plea of
1854 nolo contendere or guilty to, any of the offenses listed in s.
1855 435.04. This subsection expires October 1, 2014.
1856 (32) ~~(33)~~ The agency shall, by rule, develop a process
1857 whereby a Medicaid managed care plan enrollee who wishes to
1858 enter hospice care may be disenrolled from the managed care plan
1859 within 24 hours after contacting the agency regarding such
1860 request. The agency rule shall include a methodology for the
1861 agency to recoup managed care plan payments on a pro rata basis
1862 if payment has been made for the enrollment month when
1863 disenrollment occurs. This subsection expires October 1, 2014.
1864 (33) ~~(34)~~ The agency and entities that contract with the
1865 agency to provide health care services to Medicaid recipients
1866 under this section or ss. 409.91211 and 409.9122 must comply
1867 with the provisions of s. 641.513 in providing emergency
1868 services and care to Medicaid recipients and MediPass
1869 recipients. Where feasible, safe, and cost-effective, the agency
1870 shall encourage hospitals, emergency medical services providers,
1871 and other public and private health care providers to work
1872 together in their local communities to enter into agreements or
1873 arrangements to ensure access to alternatives to emergency
1874 services and care for those Medicaid recipients who need
1875 nonemergent care. The agency shall coordinate with hospitals,
1876 emergency medical services providers, private health plans,

1877 capitated managed care networks as established in s. 409.91211,
1878 and other public and private health care providers to implement
1879 the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405,
1880 and 641.31097 to develop and implement emergency department
1881 diversion programs for Medicaid recipients. This subsection
1882 expires October 1, 2014.
1883 (34) ~~(35)~~ All entities providing health care services to
1884 Medicaid recipients shall make available, and encourage all
1885 pregnant women and mothers with infants to receive, and provide
1886 documentation in the medical records to reflect, the following:
1887 (a) Healthy Start prenatal or infant screening.
1888 (b) Healthy Start care coordination, when screening or
1889 other factors indicate need.
1890 (c) Healthy Start enhanced services in accordance with the
1891 prenatal or infant screening results.
1892 (d) Immunizations in accordance with recommendations of
1893 the Advisory Committee on Immunization Practices of the United
1894 States Public Health Service and the American Academy of
1895 Pediatrics, as appropriate.
1896 (e) Counseling and services for family planning to all
1897 women and their partners.
1898 (f) A scheduled postpartum visit for the purpose of
1899 voluntary family planning, to include discussion of all methods
1900 of contraception, as appropriate.
1901 (g) Referral to the Special Supplemental Nutrition Program
1902 for Women, Infants, and Children (WIC).
1903
1904 This subsection expires October 1, 2014.

1905 (35) ~~(36)~~ Any entity that provides Medicaid prepaid health
1906 plan services shall ensure the appropriate coordination of
1907 health care services with an assisted living facility in cases
1908 where a Medicaid recipient is both a member of the entity's
1909 prepaid health plan and a resident of the assisted living
1910 facility. If the entity is at risk for Medicaid targeted case
1911 management and behavioral health services, the entity shall
1912 inform the assisted living facility of the procedures to follow
1913 should an emergent condition arise. This subsection expires
1914 October 1, 2014.
1915 ~~(37) The agency may seek and implement federal waivers~~
1916 ~~necessary to provide for cost-effective purchasing of home~~
1917 ~~health services, private duty nursing services, transportation,~~
1918 ~~independent laboratory services, and durable medical equipment~~
1919 ~~and supplies through competitive bidding pursuant to s. 287.057.~~
1920 ~~The agency may request appropriate waivers from the federal~~
1921 ~~Health Care Financing Administration in order to competitively~~
1922 ~~bid such services. The agency may exclude providers not selected~~
1923 ~~through the bidding process from the Medicaid provider network.~~
1924 (36) ~~(38)~~ The agency shall enter into agreements with not-
1925 for-profit organizations based in this state for the purpose of
1926 providing vision screening. This subsection expires October 1,
1927 2014.
1928 (37) ~~(39)~~(a) The agency shall implement a Medicaid
1929 prescribed-drug spending-control program that includes the
1930 following components:
1931 1. A Medicaid preferred drug list, which shall be a
1932 listing of cost-effective therapeutic options recommended by the

1933 Medicaid Pharmacy and Therapeutics Committee established
1934 pursuant to s. 409.91195 and adopted by the agency for each
1935 therapeutic class on the preferred drug list. At the discretion
1936 of the committee, and when feasible, the preferred drug list
1937 should include at least two products in a therapeutic class. The
1938 agency may post the preferred drug list and updates to the
1939 preferred drug list on an Internet website without following the
1940 rulemaking procedures of chapter 120. Antiretroviral agents are
1941 excluded from the preferred drug list. The agency shall also
1942 limit the amount of a prescribed drug dispensed to no more than
1943 a 34-day supply unless the drug products' smallest marketed
1944 package is greater than a 34-day supply, or the drug is
1945 determined by the agency to be a maintenance drug in which case
1946 a 100-day maximum supply may be authorized. The agency is
1947 authorized to seek any federal waivers necessary to implement
1948 these cost-control programs and to continue participation in the
1949 federal Medicaid rebate program, or alternatively to negotiate
1950 state-only manufacturer rebates. The agency may adopt rules to
1951 implement this subparagraph. The agency shall continue to
1952 provide unlimited contraceptive drugs and items. The agency must
1953 establish procedures to ensure that:
1954 a. There is a response to a request for prior consultation
1955 by telephone or other telecommunication device within 24 hours
1956 after receipt of a request for prior consultation; and
1957 b. A 72-hour supply of the drug prescribed is provided in
1958 an emergency or when the agency does not provide a response
1959 within 24 hours as required by sub-subparagraph a.
1960 2. Reimbursement to pharmacies for Medicaid prescribed

1961 drugs shall be set at the lesser of: the average wholesale price
1962 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
1963 plus 4.75 percent, the federal upper limit (FUL), the state
1964 maximum allowable cost (SMAC), or the usual and customary (UAC)
1965 charge billed by the provider.
1966 3. The agency shall develop and implement a process for
1967 managing the drug therapies of Medicaid recipients who are using
1968 significant numbers of prescribed drugs each month. The
1969 management process may include, but is not limited to,
1970 comprehensive, physician-directed medical-record reviews, claims
1971 analyses, and case evaluations to determine the medical
1972 necessity and appropriateness of a patient's treatment plan and
1973 drug therapies. The agency may contract with a private
1974 organization to provide drug-program-management services. The
1975 Medicaid drug benefit management program shall include
1976 initiatives to manage drug therapies for HIV/AIDS patients,
1977 patients using 20 or more unique prescriptions in a 180-day
1978 period, and the top 1,000 patients in annual spending. The
1979 agency shall enroll any Medicaid recipient in the drug benefit
1980 management program if he or she meets the specifications of this
1981 provision and is not enrolled in a Medicaid health maintenance
1982 organization.
1983 4. The agency may limit the size of its pharmacy network
1984 based on need, competitive bidding, price negotiations,
1985 credentialing, or similar criteria. The agency shall give
1986 special consideration to rural areas in determining the size and
1987 location of pharmacies included in the Medicaid pharmacy
1988 network. A pharmacy credentialing process may include criteria

1989 such as a pharmacy's full-service status, location, size,
1990 patient educational programs, patient consultation, disease
1991 management services, and other characteristics. The agency may
1992 impose a moratorium on Medicaid pharmacy enrollment when it is
1993 determined that it has a sufficient number of Medicaid-
1994 participating providers. The agency must allow dispensing
1995 practitioners to participate as a part of the Medicaid pharmacy
1996 network regardless of the practitioner's proximity to any other
1997 entity that is dispensing prescription drugs under the Medicaid
1998 program. A dispensing practitioner must meet all credentialing
1999 requirements applicable to his or her practice, as determined by
2000 the agency.
2001 5. The agency shall develop and implement a program that
2002 requires Medicaid practitioners who prescribe drugs to use a
2003 counterfeit-proof prescription pad for Medicaid prescriptions.
2004 The agency shall require the use of standardized counterfeit-
2005 proof prescription pads by Medicaid-participating prescribers or
2006 prescribers who write prescriptions for Medicaid recipients. The
2007 agency may implement the program in targeted geographic areas or
2008 statewide.
2009 6. The agency may enter into arrangements that require
2010 manufacturers of generic drugs prescribed to Medicaid recipients
2011 to provide rebates of at least 15.1 percent of the average
2012 manufacturer price for the manufacturer's generic products.
2013 These arrangements shall require that if a generic-drug
2014 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2015 at a level below 15.1 percent, the manufacturer must provide a
2016 supplemental rebate to the state in an amount necessary to

2017 achieve a 15.1-percent rebate level.
2018 7. The agency may establish a preferred drug list as
2019 described in this subsection, and, pursuant to the establishment
2020 of such preferred drug list, it is authorized to negotiate
2021 supplemental rebates from manufacturers that are in addition to
2022 those required by Title XIX of the Social Security Act and at no
2023 less than 14 percent of the average manufacturer price as
2024 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2025 the federal or supplemental rebate, or both, equals or exceeds
2026 29 percent. There is no upper limit on the supplemental rebates
2027 the agency may negotiate. The agency may determine that specific
2028 products, brand-name or generic, are competitive at lower rebate
2029 percentages. Agreement to pay the minimum supplemental rebate
2030 percentage will guarantee a manufacturer that the Medicaid
2031 Pharmaceutical and Therapeutics Committee will consider a
2032 product for inclusion on the preferred drug list. However, a
2033 pharmaceutical manufacturer is not guaranteed placement on the
2034 preferred drug list by simply paying the minimum supplemental
2035 rebate. Agency decisions will be made on the clinical efficacy
2036 of a drug and recommendations of the Medicaid Pharmaceutical and
2037 Therapeutics Committee, as well as the price of competing
2038 products minus federal and state rebates. The agency is
2039 authorized to contract with an outside agency or contractor to
2040 conduct negotiations for supplemental rebates. For the purposes
2041 of this section, the term "supplemental rebates" means cash
2042 rebates. Effective July 1, 2004, value-added programs as a
2043 substitution for supplemental rebates are prohibited. The agency
2044 is authorized to seek any federal waivers to implement this

2045 initiative.
2046 8. The Agency for Health Care Administration shall expand
2047 home delivery of pharmacy products. To assist Medicaid patients
2048 in securing their prescriptions and reduce program costs, the
2049 agency shall expand its current mail-order-pharmacy diabetes-
2050 supply program to include all generic and brand-name drugs used
2051 by Medicaid patients with diabetes. Medicaid recipients in the
2052 current program may obtain nondiabetes drugs on a voluntary
2053 basis. This initiative is limited to the geographic area covered
2054 by the current contract. The agency may seek and implement any
2055 federal waivers necessary to implement this subparagraph.
2056 9. The agency shall limit to one dose per month any drug
2057 prescribed to treat erectile dysfunction.
2058 10.a. The agency may implement a Medicaid behavioral drug
2059 management system. The agency may contract with a vendor that
2060 has experience in operating behavioral drug management systems
2061 to implement this program. The agency is authorized to seek
2062 federal waivers to implement this program.
2063 b. The agency, in conjunction with the Department of
2064 Children and Family Services, may implement the Medicaid
2065 behavioral drug management system that is designed to improve
2066 the quality of care and behavioral health prescribing practices
2067 based on best practice guidelines, improve patient adherence to
2068 medication plans, reduce clinical risk, and lower prescribed
2069 drug costs and the rate of inappropriate spending on Medicaid
2070 behavioral drugs. The program may include the following
2071 elements:
2072 (I) Provide for the development and adoption of best

2073 practice guidelines for behavioral health-related drugs such as
2074 antipsychotics, antidepressants, and medications for treating
2075 bipolar disorders and other behavioral conditions; translate
2076 them into practice; review behavioral health prescribers and
2077 compare their prescribing patterns to a number of indicators
2078 that are based on national standards; and determine deviations
2079 from best practice guidelines.
2080 (II) Implement processes for providing feedback to and
2081 educating prescribers using best practice educational materials
2082 and peer-to-peer consultation.
2083 (III) Assess Medicaid beneficiaries who are outliers in
2084 their use of behavioral health drugs with regard to the numbers
2085 and types of drugs taken, drug dosages, combination drug
2086 therapies, and other indicators of improper use of behavioral
2087 health drugs.
2088 (IV) Alert prescribers to patients who fail to refill
2089 prescriptions in a timely fashion, are prescribed multiple same-
2090 class behavioral health drugs, and may have other potential
2091 medication problems.
2092 (V) Track spending trends for behavioral health drugs and
2093 deviation from best practice guidelines.
2094 (VI) Use educational and technological approaches to
2095 promote best practices, educate consumers, and train prescribers
2096 in the use of practice guidelines.
2097 (VII) Disseminate electronic and published materials.
2098 (VIII) Hold statewide and regional conferences.
2099 (IX) Implement a disease management program with a model
2100 quality-based medication component for severely mentally ill

2101 individuals and emotionally disturbed children who are high
2102 users of care.
2103 11.a. The agency shall implement a Medicaid prescription
2104 drug management system. The agency may contract with a vendor
2105 that has experience in operating prescription drug management
2106 systems in order to implement this system. Any management system
2107 that is implemented in accordance with this subparagraph must
2108 rely on cooperation between physicians and pharmacists to
2109 determine appropriate practice patterns and clinical guidelines
2110 to improve the prescribing, dispensing, and use of drugs in the
2111 Medicaid program. The agency may seek federal waivers to
2112 implement this program.
2113 b. The drug management system must be designed to improve
2114 the quality of care and prescribing practices based on best
2115 practice guidelines, improve patient adherence to medication
2116 plans, reduce clinical risk, and lower prescribed drug costs and
2117 the rate of inappropriate spending on Medicaid prescription
2118 drugs. The program must:
2119 (I) Provide for the development and adoption of best
2120 practice guidelines for the prescribing and use of drugs in the
2121 Medicaid program, including translating best practice guidelines
2122 into practice; reviewing prescriber patterns and comparing them
2123 to indicators that are based on national standards and practice
2124 patterns of clinical peers in their community, statewide, and
2125 nationally; and determine deviations from best practice
2126 guidelines.
2127 (II) Implement processes for providing feedback to and
2128 educating prescribers using best practice educational materials

2129 and peer-to-peer consultation.
2130 (III) Assess Medicaid recipients who are outliers in their
2131 use of a single or multiple prescription drugs with regard to
2132 the numbers and types of drugs taken, drug dosages, combination
2133 drug therapies, and other indicators of improper use of
2134 prescription drugs.
2135 (IV) Alert prescribers to patients who fail to refill
2136 prescriptions in a timely fashion, are prescribed multiple drugs
2137 that may be redundant or contraindicated, or may have other
2138 potential medication problems.
2139 (V) Track spending trends for prescription drugs and
2140 deviation from best practice guidelines.
2141 (VI) Use educational and technological approaches to
2142 promote best practices, educate consumers, and train prescribers
2143 in the use of practice guidelines.
2144 (VII) Disseminate electronic and published materials.
2145 (VIII) Hold statewide and regional conferences.
2146 (IX) Implement disease management programs in cooperation
2147 with physicians and pharmacists, along with a model quality-
2148 based medication component for individuals having chronic
2149 medical conditions.
2150 12. The agency is authorized to contract for drug rebate
2151 administration, including, but not limited to, calculating
2152 rebate amounts, invoicing manufacturers, negotiating disputes
2153 with manufacturers, and maintaining a database of rebate
2154 collections.
2155 13. The agency may specify the preferred daily dosing form
2156 or strength for the purpose of promoting best practices with

2157 regard to the prescribing of certain drugs as specified in the
2158 General Appropriations Act and ensuring cost-effective
2159 prescribing practices.
2160 14. The agency may require prior authorization for
2161 Medicaid-covered prescribed drugs. The agency may, but is not
2162 required to, prior-authorize the use of a product:
2163 a. For an indication not approved in labeling;
2164 b. To comply with certain clinical guidelines; or
2165 c. If the product has the potential for overuse, misuse,
2166 or abuse.
2167
2168 The agency may require the prescribing professional to provide
2169 information about the rationale and supporting medical evidence
2170 for the use of a drug. The agency may post prior authorization
2171 criteria and protocol and updates to the list of drugs that are
2172 subject to prior authorization on an Internet website without
2173 amending its rule or engaging in additional rulemaking.
2174 15. The agency, in conjunction with the Pharmaceutical and
2175 Therapeutics Committee, may require age-related prior
2176 authorizations for certain prescribed drugs. The agency may
2177 preauthorize the use of a drug for a recipient who may not meet
2178 the age requirement or may exceed the length of therapy for use
2179 of this product as recommended by the manufacturer and approved
2180 by the Food and Drug Administration. Prior authorization may
2181 require the prescribing professional to provide information
2182 about the rationale and supporting medical evidence for the use
2183 of a drug.
2184 16. The agency shall implement a step-therapy prior

2185 authorization approval process for medications excluded from the
2186 preferred drug list. Medications listed on the preferred drug
2187 list must be used within the previous 12 months prior to the
2188 alternative medications that are not listed. The step-therapy
2189 prior authorization may require the prescriber to use the
2190 medications of a similar drug class or for a similar medical
2191 indication unless contraindicated in the Food and Drug
2192 Administration labeling. The trial period between the specified
2193 steps may vary according to the medical indication. The step-
2194 therapy approval process shall be developed in accordance with
2195 the committee as stated in s. 409.91195(7) and (8). A drug
2196 product may be approved without meeting the step-therapy prior
2197 authorization criteria if the prescribing physician provides the
2198 agency with additional written medical or clinical documentation
2199 that the product is medically necessary because:
2200 a. There is not a drug on the preferred drug list to treat
2201 the disease or medical condition which is an acceptable clinical
2202 alternative;
2203 b. The alternatives have been ineffective in the treatment
2204 of the beneficiary's disease; or
2205 c. Based on historic evidence and known characteristics of
2206 the patient and the drug, the drug is likely to be ineffective,
2207 or the number of doses have been ineffective.
2208
2209 The agency shall work with the physician to determine the best
2210 alternative for the patient. The agency may adopt rules waiving
2211 the requirements for written clinical documentation for specific
2212 drugs in limited clinical situations.

2213 17. The agency shall implement a return and reuse program
2214 for drugs dispensed by pharmacies to institutional recipients,
2215 which includes payment of a $5 restocking fee for the
2216 implementation and operation of the program. The return and
2217 reuse program shall be implemented electronically and in a
2218 manner that promotes efficiency. The program must permit a
2219 pharmacy to exclude drugs from the program if it is not
2220 practical or cost-effective for the drug to be included and must
2221 provide for the return to inventory of drugs that cannot be
2222 credited or returned in a cost-effective manner. The agency
2223 shall determine if the program has reduced the amount of
2224 Medicaid prescription drugs which are destroyed on an annual
2225 basis and if there are additional ways to ensure more
2226 prescription drugs are not destroyed which could safely be
2227 reused. The agency's conclusion and recommendations shall be
2228 reported to the Legislature by December 1, 2005.
2229 (b) The agency shall implement this subsection to the
2230 extent that funds are appropriated to administer the Medicaid
2231 prescribed-drug spending-control program. The agency may
2232 contract all or any part of this program to private
2233 organizations.
2234 (c) The agency shall submit quarterly reports to the
2235 Governor, the President of the Senate, and the Speaker of the
2236 House of Representatives which must include, but need not be
2237 limited to, the progress made in implementing this subsection
2238 and its effect on Medicaid prescribed-drug expenditures.
2239 (38) ~~(40)~~ Notwithstanding the provisions of chapter 287,
2240 the agency may, at its discretion, renew a contract or contracts

2241 for fiscal intermediary services one or more times for such
2242 periods as the agency may decide; however, all such renewals may
2243 not combine to exceed a total period longer than the term of the
2244 original contract.

2245 (39) ~~(41)~~ The agency shall provide for the development of
2246 a demonstration project by establishment in Miami-Dade County of
2247 a long-term-care facility licensed pursuant to chapter 395 to
2248 improve access to health care for a predominantly minority,
2249 medically underserved, and medically complex population and to
2250 evaluate alternatives to nursing home care and general acute
2251 care for such population. Such project is to be located in a
2252 health care condominium and colocated with licensed facilities
2253 providing a continuum of care. The establishment of this project
2254 is not subject to the provisions of s. 408.036 or s. 408.039.
2255 This subsection expires October 1, 2013.

2256 ~~(42) The agency shall develop and implement a utilization~~
2257 ~~management program for Medicaid-eligible recipients for the~~
2258 ~~management of occupational, physical, respiratory, and speech~~
2259 ~~therapies. The agency shall establish a utilization program that~~
2260 ~~may require prior authorization in order to ensure medically~~
2261 ~~necessary and cost-effective treatments. The program shall be~~
2262 ~~operated in accordance with a federally approved waiver program~~
2263 ~~or state plan amendment. The agency may seek a federal waiver or~~
2264 ~~state plan amendment to implement this program. The agency may~~
2265 ~~also competitively procure these services from an outside vendor~~
2266 ~~on a regional or statewide basis.~~

2267 (40) ~~(43)~~ The agency shall ~~may~~ contract on a prepaid or
2268 fixed-sum basis with appropriately licensed prepaid dental

2269 health plans to provide dental services. This subsection
2270 expires October 1, 2014.
2271 (41) ~~(44)~~ The Agency for Health Care Administration shall
2272 ensure that any Medicaid managed care plan as defined in s.
2273 409.9122(2)(f), whether paid on a capitated basis or a shared
2274 savings basis, is cost-effective. For purposes of this
2275 subsection, the term "cost-effective" means that a network's
2276 per-member, per-month costs to the state, including, but not
2277 limited to, fee-for-service costs, administrative costs, and
2278 case-management fees, if any, must be no greater than the
2279 state's costs associated with contracts for Medicaid services
2280 established under subsection (3), which may be adjusted for
2281 health status. The agency shall conduct actuarially sound
2282 adjustments for health status in order to ensure such cost-
2283 effectiveness and shall annually publish the results on its
2284 Internet website. Contracts established pursuant to this
2285 subsection which are not cost-effective may not be renewed.
2286 This subsection expires October 1, 2014.
2287 (42) ~~(45)~~ Subject to the availability of funds, the agency
2288 shall mandate a recipient's participation in a provider lock-in
2289 program, when appropriate, if a recipient is found by the agency
2290 to have used Medicaid goods or services at a frequency or amount
2291 not medically necessary, limiting the receipt of goods or
2292 services to medically necessary providers after the 21-day
2293 appeal process has ended, for a period of not less than 1 year.
2294 The lock-in programs shall include, but are not limited to,
2295 pharmacies, medical doctors, and infusion clinics. The
2296 limitation does not apply to emergency services and care

2297 provided to the recipient in a hospital emergency department.
2298 The agency shall seek any federal waivers necessary to implement
2299 this subsection. The agency shall adopt any rules necessary to
2300 comply with or administer this subsection. This subsection
2301 expires October 1, 2014.
2302 (43) ~~(46)~~ The agency shall seek a federal waiver for
2303 permission to terminate the eligibility of a Medicaid recipient
2304 who has been found to have committed fraud, through judicial or
2305 administrative determination, two times in a period of 5 years.
2306 ~~(47) The agency shall conduct a study of available~~
2307 ~~electronic systems for the purpose of verifying the identity and~~
2308 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
2309 ~~to the Legislature a plan to implement an electronic~~
2310 ~~verification system for Medicaid recipients by January 31, 2005.~~
2311 (44) ~~(48)~~(a) A provider is not entitled to enrollment in
2312 the Medicaid provider network. The agency may implement a
2313 Medicaid fee-for-service provider network controls, including,
2314 but not limited to, competitive procurement and provider
2315 credentialing. If a credentialing process is used, the agency
2316 may limit its provider network based upon the following
2317 considerations: beneficiary access to care, provider
2318 availability, provider quality standards and quality assurance
2319 processes, cultural competency, demographic characteristics of
2320 beneficiaries, practice standards, service wait times, provider
2321 turnover, provider licensure and accreditation history, program
2322 integrity history, peer review, Medicaid policy and billing
2323 compliance records, clinical and medical record audit findings,
2324 and such other areas that are considered necessary by the agency

2325 to ensure the integrity of the program.
2326 (b) The agency shall limit its network of durable medical
2327 equipment and medical supply providers. For dates of service
2328 after January 1, 2009, the agency shall limit payment for
2329 durable medical equipment and supplies to providers that meet
2330 all the requirements of this paragraph.
2331 1. Providers must be accredited by a Centers for Medicare
2332 and Medicaid Services deemed accreditation organization for
2333 suppliers of durable medical equipment, prosthetics, orthotics,
2334 and supplies. The provider must maintain accreditation and is
2335 subject to unannounced reviews by the accrediting organization.
2336 2. Providers must provide the services or supplies
2337 directly to the Medicaid recipient or caregiver at the provider
2338 location or recipient's residence or send the supplies directly
2339 to the recipient's residence with receipt of mailed delivery.
2340 Subcontracting or consignment of the service or supply to a
2341 third party is prohibited.
2342 3. Notwithstanding subparagraph 2., a durable medical
2343 equipment provider may store nebulizers at a physician's office
2344 for the purpose of having the physician's staff issue the
2345 equipment if it meets all of the following conditions:
2346 a. The physician must document the medical necessity and
2347 need to prevent further deterioration of the patient's
2348 respiratory status by the timely delivery of the nebulizer in
2349 the physician's office.
2350 b. The durable medical equipment provider must have
2351 written documentation of the competency and training by a
2352 Florida-licensed registered respiratory therapist of any durable

2353 medical equipment staff who participate in the training of
2354 physician office staff for the use of nebulizers, including
2355 cleaning, warranty, and special needs of patients.
2356 c. The physician's office must have documented the
2357 training and competency of any staff member who initiates the
2358 delivery of nebulizers to patients. The durable medical
2359 equipment provider must maintain copies of all physician office
2360 training.
2361 d. The physician's office must maintain inventory records
2362 of stored nebulizers, including documentation of the durable
2363 medical equipment provider source.
2364 e. A physician contracted with a Medicaid durable medical
2365 equipment provider may not have a financial relationship with
2366 that provider or receive any financial gain from the delivery of
2367 nebulizers to patients.
2368 4. Providers must have a physical business location and a
2369 functional landline business phone. The location must be within
2370 the state or not more than 50 miles from the Florida state line.
2371 The agency may make exceptions for providers of durable medical
2372 equipment or supplies not otherwise available from other
2373 enrolled providers located within the state.
2374 5. Physical business locations must be clearly identified
2375 as a business that furnishes durable medical equipment or
2376 medical supplies by signage that can be read from 20 feet away.
2377 The location must be readily accessible to the public during
2378 normal, posted business hours and must operate at least 5 hours
2379 per day and at least 5 days per week, with the exception of
2380 scheduled and posted holidays. The location may not be located

2381 within or at the same numbered street address as another
2382 enrolled Medicaid durable medical equipment or medical supply
2383 provider or as an enrolled Medicaid pharmacy that is also
2384 enrolled as a durable medical equipment provider. A licensed
2385 orthotist or prosthetist that provides only orthotic or
2386 prosthetic devices as a Medicaid durable medical equipment
2387 provider is exempt from this paragraph.
2388 6. Providers must maintain a stock of durable medical
2389 equipment and medical supplies on site that is readily available
2390 to meet the needs of the durable medical equipment business
2391 location's customers.
2392 7. Providers must provide a surety bond of $50,000 for
2393 each provider location, up to a maximum of 5 bonds statewide or
2394 an aggregate bond of $250,000 statewide, as identified by
2395 Federal Employer Identification Number. Providers who post a
2396 statewide or an aggregate bond must identify all of their
2397 locations in any Medicaid durable medical equipment and medical
2398 supply provider enrollment application or bond renewal. Each
2399 provider location's surety bond must be renewed annually and the
2400 provider must submit proof of renewal even if the original bond
2401 is a continuous bond. A licensed orthotist or prosthetist that
2402 provides only orthotic or prosthetic devices as a Medicaid
2403 durable medical equipment provider is exempt from the provisions
2404 in this paragraph.
2405 8. Providers must obtain a level 2 background screening,
2406 in accordance with chapter 435 and s. 408.809, for each provider
2407 employee in direct contact with or providing direct services to
2408 recipients of durable medical equipment and medical supplies in

2409 their homes. This requirement includes, but is not limited to,
2410 repair and service technicians, fitters, and delivery staff. The
2411 provider shall pay for the cost of the background screening.
2412 9. The following providers are exempt from subparagraphs
2413 1. and 7.:
2414 a. Durable medical equipment providers owned and operated
2415 by a government entity.
2416 b. Durable medical equipment providers that are operating
2417 within a pharmacy that is currently enrolled as a Medicaid
2418 pharmacy provider.
2419 c. Active, Medicaid-enrolled orthopedic physician groups,
2420 primarily owned by physicians, which provide only orthotic and
2421 prosthetic devices.
2422 (45) ~~(49)~~ The agency shall contract with established
2423 minority physician networks that provide services to
2424 historically underserved minority patients. The networks must
2425 provide cost-effective Medicaid services, comply with the
2426 requirements to be a MediPass provider, and provide their
2427 primary care physicians with access to data and other management
2428 tools necessary to assist them in ensuring the appropriate use
2429 of services, including inpatient hospital services and
2430 pharmaceuticals.
2431 (a) The agency shall provide for the development and
2432 expansion of minority physician networks in each service area to
2433 provide services to Medicaid recipients who are eligible to
2434 participate under federal law and rules.
2435 (b) The agency shall reimburse each minority physician
2436 network as a fee-for-service provider, including the case

2437 management fee for primary care, if any, or as a capitated rate
2438 provider for Medicaid services. Any savings shall be shared with
2439 the minority physician networks pursuant to the contract.
2440 (c) For purposes of this subsection, the term "cost-
2441 effective" means that a network's per-member, per-month costs to
2442 the state, including, but not limited to, fee-for-service costs,
2443 administrative costs, and case-management fees, if any, must be
2444 no greater than the state's costs associated with contracts for
2445 Medicaid services established under subsection (3), which shall
2446 be actuarially adjusted for case mix, model, and service area.
2447 The agency shall conduct actuarially sound audits adjusted for
2448 case mix and model in order to ensure such cost-effectiveness
2449 and shall annually publish the audit results on its Internet
2450 website. Contracts established pursuant to this subsection which
2451 are not cost-effective may not be renewed.
2452 (d) The agency may apply for any federal waivers needed to
2453 implement this subsection.
2454
2455 This subsection expires October 1, 2014.
2456 (46) (50) To the extent permitted by federal law and as
2457 allowed under s. 409.906, the agency shall provide reimbursement
2458 for emergency mental health care services for Medicaid
2459 recipients in crisis stabilization facilities licensed under s.
2460 394.875 as long as those services are less expensive than the
2461 same services provided in a hospital setting.
2462 (47) (51) The agency shall work with the Agency for
2463 Persons with Disabilities to develop a home and community-based
2464 waiver to serve children and adults who are diagnosed with

2465 familial dysautonomia or Riley-Day syndrome caused by a mutation
2466 of the IKBKAP gene on chromosome 9. The agency shall seek
2467 federal waiver approval and implement the approved waiver
2468 subject to the availability of funds and any limitations
2469 provided in the General Appropriations Act. The agency may adopt
2470 rules to implement this waiver program.
2471 <u>(48)</u> ~~(52)~~ The agency shall implement a program of all-
2472 inclusive care for children. The program of all-inclusive care
2473 for children shall be established to provide in-home hospice-
2474 like support services to children diagnosed with a life-
2475 threatening illness and enrolled in the Children's Medical
2476 Services network to reduce hospitalizations as appropriate. The
2477 agency, in consultation with the Department of Health, may
2478 implement the program of all-inclusive care for children after
2479 obtaining approval from the Centers for Medicare and Medicaid
2480 Services.
2481 <u>(49)</u> ~~(53)~~ Before seeking an amendment to the state plan
2482 for purposes of implementing programs authorized by the Deficit
2483 Reduction Act of 2005, the agency shall notify the Legislature.
2484 Section 11. Subsection (4) of section 409.91195, Florida
2485 Statutes, is amended to read:
2486 409.91195 Medicaid Pharmaceutical and Therapeutics
2487 Committee.—There is created a Medicaid Pharmaceutical and
2488 Therapeutics Committee within the agency for the purpose of
2489 developing a Medicaid preferred drug list.
2490 (4) Upon recommendation of the committee, the agency shall
2491 adopt a preferred drug list as described in s. 409.912 <u>(37)</u>
2492 ~~(39)~~. To the extent feasible, the committee shall review all

2493 drug classes included on the preferred drug list every 12
2494 months, and may recommend additions to and deletions from the
2495 preferred drug list, such that the preferred drug list provides
2496 for medically appropriate drug therapies for Medicaid patients
2497 which achieve cost savings contained in the General
2498 Appropriations Act.

2499 Section 12. Subsection (1) of section 409.91196, Florida
2500 Statutes, is amended to read:

2501 409.91196 Supplemental rebate agreements; public records
2502 and public meetings exemption.—

2503 (1) The rebate amount, percent of rebate, manufacturer's
2504 pricing, and supplemental rebate, and other trade secrets as
2505 defined in s. 688.002 that the agency has identified for use in
2506 negotiations, held by the Agency for Health Care Administration
2507 under s. 409.912 (37) ~~(39)~~(a)7. are confidential and exempt from
2508 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

2509 Section 13. Section 409.91207, Florida Statutes, is
2510 repealed.

2511 Section 14. Effective October 1, 2014, section 409.91211,
2512 Florida Statutes, is repealed.

2513 Section 15. Section 409.9122, Florida Statutes, is amended
2514 to read:

2515 409.9122 Mandatory Medicaid managed care enrollment;
2516 programs and procedures.—

2517 (1) It is the intent of the Legislature that the MediPass
2518 program be cost-effective, provide quality health care, and
2519 improve access to health services, and that the program be
2520 statewide. This subsection expires October 1, 2014.

2521 (2)(a) The agency shall enroll in a managed care plan or
2522 MediPass all Medicaid recipients, except those Medicaid
2523 recipients who are: in an institution; enrolled in the Medicaid
2524 medically needy program; or eligible for both Medicaid and
2525 Medicare. Upon enrollment, individuals will be able to change
2526 their managed care option during the 90-day opt out period
2527 required by federal Medicaid regulations. The agency is
2528 authorized to seek the necessary Medicaid state plan amendment
2529 to implement this policy. However, to the extent permitted by
2530 federal law, the agency may enroll in a managed care plan or
2531 MediPass a Medicaid recipient who is exempt from mandatory
2532 managed care enrollment, provided that:
2533 1. The recipient's decision to enroll in a managed care
2534 plan or MediPass is voluntary;
2535 2. If the recipient chooses to enroll in a managed care
2536 plan, the agency has determined that the managed care plan
2537 provides specific programs and services which address the
2538 special health needs of the recipient; and
2539 3. The agency receives any necessary waivers from the
2540 federal Centers for Medicare and Medicaid Services.
2541
2542 ~~The agency shall develop rules to establish policies by which~~
2543 ~~exceptions to the mandatory managed care enrollment requirement~~
2544 ~~may be made on a case-by-case basis. The rules shall include the~~
2545 ~~specific criteria to be applied when making a determination as~~
2546 ~~to whether to exempt a recipient from mandatory enrollment in a~~
2547 ~~managed care plan or MediPass.~~ School districts participating in
2548 the certified school match program pursuant to ss. 409.908(21)

2549 and 1011.70 shall be reimbursed by Medicaid, subject to the
2550 limitations of s. 1011.70(1), for a Medicaid-eligible child
2551 participating in the services as authorized in s. 1011.70, as
2552 provided for in s. 409.9071, regardless of whether the child is
2553 enrolled in MediPass or a managed care plan. Managed care plans
2554 shall make a good faith effort to execute agreements with school
2555 districts regarding the coordinated provision of services
2556 authorized under s. 1011.70. County health departments
2557 delivering school-based services pursuant to ss. 381.0056 and
2558 381.0057 shall be reimbursed by Medicaid for the federal share
2559 for a Medicaid-eligible child who receives Medicaid-covered
2560 services in a school setting, regardless of whether the child is
2561 enrolled in MediPass or a managed care plan. Managed care plans
2562 shall make a good faith effort to execute agreements with county
2563 health departments regarding the coordinated provision of
2564 services to a Medicaid-eligible child. To ensure continuity of
2565 care for Medicaid patients, the agency, the Department of
2566 Health, and the Department of Education shall develop procedures
2567 for ensuring that a student's managed care plan or MediPass
2568 provider receives information relating to services provided in
2569 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
2570 (b) A Medicaid recipient shall not be enrolled in or
2571 assigned to a managed care plan or MediPass unless the managed
2572 care plan or MediPass has complied with the quality-of-care
2573 standards specified in paragraphs (3)(a) and (b), respectively.
2574 (c) Medicaid recipients shall have a choice of managed
2575 care plans or MediPass. The Agency for Health Care
2576 Administration, the Department of Health, the Department of

2577 Children and Family Services, and the Department of Elderly
2578 Affairs shall cooperate to ensure that each Medicaid recipient
2579 receives clear and easily understandable information that meets
2580 the following requirements:
2581 1. Explains the concept of managed care, including
2582 MediPass.
2583 2. Provides information on the comparative performance of
2584 managed care plans and MediPass in the areas of quality,
2585 credentialing, preventive health programs, network size and
2586 availability, and patient satisfaction.
2587 3. Explains where additional information on each managed
2588 care plan and MediPass in the recipient's area can be obtained.
2589 4. Explains that recipients have the right to choose their
2590 managed care coverage at the time they first enroll in Medicaid
2591 and again at regular intervals set by the agency. However, if a
2592 recipient does not choose a managed care plan or MediPass, the
2593 agency will assign the recipient to a managed care plan or
2594 MediPass according to the criteria specified in this section.
2595 5. Explains the recipient's right to complain, file a
2596 grievance, or change managed care plans or MediPass providers if
2597 the recipient is not satisfied with the managed care plan or
2598 MediPass.
2599 (d) The agency shall develop a mechanism for providing
2600 information to Medicaid recipients for the purpose of making a
2601 managed care plan or MediPass selection. Examples of such
2602 mechanisms may include, but not be limited to, interactive
2603 information systems, mailings, and mass marketing materials.
2604 Managed care plans and MediPass providers are prohibited from

2605 providing inducements to Medicaid recipients to select their
2606 plans or from prejudicing Medicaid recipients against other
2607 managed care plans or MediPass providers.
2608 (e) Medicaid recipients who are already enrolled in a
2609 managed care plan or MediPass shall be offered the opportunity
2610 to change managed care plans or MediPass providers on a
2611 staggered basis, as defined by the agency. All Medicaid
2612 recipients shall have 30 days in which to make a choice of
2613 managed care plans or MediPass providers. Those Medicaid
2614 recipients who do not make a choice shall be assigned in
2615 accordance with paragraph (f). To facilitate continuity of care,
2616 for a Medicaid recipient who is also a recipient of Supplemental
2617 Security Income (SSI), prior to assigning the SSI recipient to a
2618 managed care plan or MediPass, the agency shall determine
2619 whether the SSI recipient has an ongoing relationship with a
2620 MediPass provider or managed care plan, and if so, the agency
2621 shall assign the SSI recipient to that MediPass provider or
2622 managed care plan. Those SSI recipients who do not have such a
2623 provider relationship shall be assigned to a managed care plan
2624 or MediPass provider in accordance with paragraph (f).
2625 (f) If a Medicaid recipient does not choose a managed care
2626 plan or MediPass provider, the agency shall assign the Medicaid
2627 recipient to a managed care plan or MediPass provider. Medicaid
2628 recipients eligible for managed care plan enrollment who are
2629 subject to mandatory assignment but who fail to make a choice
2630 shall be assigned to managed care plans until an enrollment of
2631 35 percent in MediPass and 65 percent in managed care plans, of
2632 all those eligible to choose managed care, is achieved. Once

2633 this enrollment is achieved, the assignments shall be divided in
2634 order to maintain an enrollment in MediPass and managed care
2635 plans which is in a 35 percent and 65 percent proportion,
2636 respectively. Thereafter, assignment of Medicaid recipients who
2637 fail to make a choice shall be based proportionally on the
2638 preferences of recipients who have made a choice in the previous
2639 period. Such proportions shall be revised at least quarterly to
2640 reflect an update of the preferences of Medicaid recipients. The
2641 agency shall disproportionately assign Medicaid-eligible
2642 recipients who are required to but have failed to make a choice
2643 of managed care plan or MediPass, ~~including children, and who~~
2644 ~~would be assigned to the MediPass program to children's networks~~
2645 ~~as described in s. 409.912(4)(g),~~ Children's Medical Services
2646 Network as defined in s. 391.021, exclusive provider
2647 organizations, provider service networks, minority physician
2648 networks, and pediatric emergency department diversion programs
2649 authorized by this chapter or the General Appropriations Act, in
2650 such manner as the agency deems appropriate, until the agency
2651 has determined that the networks and programs have sufficient
2652 numbers to be operated economically. For purposes of this
2653 paragraph, when referring to assignment, the term "managed care
2654 plans" includes health maintenance organizations, exclusive
2655 provider organizations, provider service networks, minority
2656 physician networks, Children's Medical Services Network, and
2657 pediatric emergency department diversion programs authorized by
2658 this chapter or the General Appropriations Act. When making
2659 assignments, the agency shall take into account the following
2660 criteria:

2661 1. A managed care plan has sufficient network capacity to
2662 meet the need of members.
2663 2. The managed care plan or MediPass has previously
2664 enrolled the recipient as a member, or one of the managed care
2665 plan's primary care providers or MediPass providers has
2666 previously provided health care to the recipient.
2667 3. The agency has knowledge that the member has previously
2668 expressed a preference for a particular managed care plan or
2669 MediPass provider as indicated by Medicaid fee-for-service
2670 claims data, but has failed to make a choice.
2671 4. The managed care plan's or MediPass primary care
2672 providers are geographically accessible to the recipient's
2673 residence.
2674 (g) When more than one managed care plan or MediPass
2675 provider meets the criteria specified in paragraph (f), the
2676 agency shall make recipient assignments consecutively by family
2677 unit.
2678 (h) The agency may not engage in practices that are
2679 designed to favor one managed care plan over another or that are
2680 designed to influence Medicaid recipients to enroll in MediPass
2681 rather than in a managed care plan or to enroll in a managed
2682 care plan rather than in MediPass. This subsection does not
2683 prohibit the agency from reporting on the performance of
2684 MediPass or any managed care plan, as measured by performance
2685 criteria developed by the agency.
2686 (i) After a recipient has made his or her selection or has
2687 been enrolled in a managed care plan or MediPass, the recipient
2688 shall have 90 days to exercise the opportunity to voluntarily

2689 disenroll and select another managed care plan or MediPass.
2690 After 90 days, no further changes may be made except for good
2691 cause. Good cause includes, but is not limited to, poor quality
2692 of care, lack of access to necessary specialty services, an
2693 unreasonable delay or denial of service, or fraudulent
2694 enrollment. The agency shall develop criteria for good cause
2695 disenrollment for chronically ill and disabled populations who
2696 are assigned to managed care plans if more appropriate care is
2697 available through the MediPass program. The agency must make a
2698 determination as to whether cause exists. However, the agency
2699 may require a recipient to use the managed care plan's or
2700 MediPass grievance process prior to the agency's determination
2701 of cause, except in cases in which immediate risk of permanent
2702 damage to the recipient's health is alleged. The grievance
2703 process, when utilized, must be completed in time to permit the
2704 recipient to disenroll by the first day of the second month
2705 after the month the disenrollment request was made. If the
2706 managed care plan or MediPass, as a result of the grievance
2707 process, approves an enrollee's request to disenroll, the agency
2708 is not required to make a determination in the case. The agency
2709 must make a determination and take final action on a recipient's
2710 request so that disenrollment occurs no later than the first day
2711 of the second month after the month the request was made. If the
2712 agency fails to act within the specified timeframe, the
2713 recipient's request to disenroll is deemed to be approved as of
2714 the date agency action was required. Recipients who disagree
2715 with the agency's finding that cause does not exist for
2716 disenrollment shall be advised of their right to pursue a

2717 Medicaid fair hearing to dispute the agency's finding.
2718 (j) The agency shall apply for a federal waiver from the
2719 Centers for Medicare and Medicaid Services to lock eligible
2720 Medicaid recipients into a managed care plan or MediPass for 12
2721 months after an open enrollment period. After 12 months'
2722 enrollment, a recipient may select another managed care plan or
2723 MediPass provider. However, nothing shall prevent a Medicaid
2724 recipient from changing primary care providers within the
2725 managed care plan or MediPass program during the 12-month
2726 period.
2727 (k) When a Medicaid recipient does not choose a managed
2728 care plan or MediPass provider, the agency shall assign the
2729 Medicaid recipient to a managed care plan, except in those
2730 counties in which there are fewer than two managed care plans
2731 accepting Medicaid enrollees, in which case assignment shall be
2732 to a managed care plan or a MediPass provider. Medicaid
2733 recipients in counties with fewer than two managed care plans
2734 accepting Medicaid enrollees who are subject to mandatory
2735 assignment but who fail to make a choice shall be assigned to
2736 managed care plans until an enrollment of 35 percent in MediPass
2737 and 65 percent in managed care plans, of all those eligible to
2738 choose managed care, is achieved. Once that enrollment is
2739 achieved, the assignments shall be divided in order to maintain
2740 an enrollment in MediPass and managed care plans which is in a
2741 35 percent and 65 percent proportion, respectively. For purposes
2742 of this paragraph, when referring to assignment, the term
2743 "managed care plans" includes exclusive provider organizations,
2744 provider service networks, Children's Medical Services Network,

2745 minority physician networks, and pediatric emergency department
2746 diversion programs authorized by this chapter or the General
2747 Appropriations Act. When making assignments, the agency shall
2748 take into account the following criteria:
2749 1. A managed care plan has sufficient network capacity to
2750 meet the need of members.
2751 2. The managed care plan or MediPass has previously
2752 enrolled the recipient as a member, or one of the managed care
2753 plan's primary care providers or MediPass providers has
2754 previously provided health care to the recipient.
2755 3. The agency has knowledge that the member has previously
2756 expressed a preference for a particular managed care plan or
2757 MediPass provider as indicated by Medicaid fee-for-service
2758 claims data, but has failed to make a choice.
2759 4. The managed care plan's or MediPass primary care
2760 providers are geographically accessible to the recipient's
2761 residence.
2762 5. The agency has authority to make mandatory assignments
2763 based on quality of service and performance of managed care
2764 plans.
2765 (l) Notwithstanding the provisions of chapter 287, the
2766 agency may, at its discretion, renew cost-effective contracts
2767 for choice counseling services once or more for such periods as
2768 the agency may decide. However, all such renewals may not
2769 combine to exceed a total period longer than the term of the
2770 original contract.
2771
2772 This subsection expires October 1, 2014.

2773 (3)(a) The agency shall establish quality-of-care
2774 standards for managed care plans. These standards shall be based
2775 upon, but are not limited to:
2776 1. Compliance with the accreditation requirements as
2777 provided in s. 641.512.
2778 2. Compliance with Early and Periodic Screening,
2779 Diagnosis, and Treatment screening requirements.
2780 3. The percentage of voluntary disenrollments.
2781 4. Immunization rates.
2782 5. Standards of the National Committee for Quality
2783 Assurance and other approved accrediting bodies.
2784 6. Recommendations of other authoritative bodies.
2785 7. Specific requirements of the Medicaid program, or
2786 standards designed to specifically assist the unique needs of
2787 Medicaid recipients.
2788 8. Compliance with the health quality improvement system
2789 as established by the agency, which incorporates standards and
2790 guidelines developed by the Medicaid Bureau of the Health Care
2791 Financing Administration as part of the quality assurance reform
2792 initiative.
2793 (b) For the MediPass program, the agency shall establish
2794 standards which are based upon, but are not limited to:
2795 1. Quality-of-care standards which are comparable to those
2796 required of managed care plans.
2797 2. Credentialing standards for MediPass providers.
2798 3. Compliance with Early and Periodic Screening,
2799 Diagnosis, and Treatment screening requirements.
2800 4. Immunization rates.

2801 5. Specific requirements of the Medicaid program, or
2802 standards designed to specifically assist the unique needs of
2803 Medicaid recipients.
2804
2805 This subsection expires October 1, 2014.
2806 (4)(a) Each female recipient may select as her primary
2807 care provider an obstetrician/gynecologist who has agreed to
2808 participate as a MediPass primary care case manager.
2809 (b) The agency shall establish a complaints and grievance
2810 process to assist Medicaid recipients enrolled in the MediPass
2811 program to resolve complaints and grievances. The agency shall
2812 investigate reports of quality-of-care grievances which remain
2813 unresolved to the satisfaction of the enrollee.
2814
2815 This subsection expires October 1, 2014.
2816 (5)(a) The agency shall work cooperatively with the Social
2817 Security Administration to identify beneficiaries who are
2818 jointly eligible for Medicare and Medicaid and shall develop
2819 cooperative programs to encourage these beneficiaries to enroll
2820 in a Medicare participating health maintenance organization or
2821 prepaid health plans.
2822 (b) The agency shall work cooperatively with the
2823 Department of Elderly Affairs to assess the potential cost-
2824 effectiveness of providing MediPass to beneficiaries who are
2825 jointly eligible for Medicare and Medicaid on a voluntary choice
2826 basis. If the agency determines that enrollment of these
2827 beneficiaries in MediPass has the potential for being cost-
2828 effective for the state, the agency shall offer MediPass to

2829 these beneficiaries on a voluntary choice basis in the counties
2830 where MediPass operates.
2831
2832 This subsection expires October 1, 2014.
2833 (6) MediPass enrolled recipients may receive up to 10
2834 visits of reimbursable services by participating Medicaid
2835 physicians licensed under chapter 460 and up to four visits of
2836 reimbursable services by participating Medicaid physicians
2837 licensed under chapter 461. Any further visits must be by prior
2838 authorization by the MediPass primary care provider. However,
2839 nothing in this subsection may be construed to increase the
2840 total number of visits or the total amount of dollars per year
2841 per person under current Medicaid rules, unless otherwise
2842 provided for in the General Appropriations Act. This subsection
2843 expires October 1, 2014.
2844 ~~(7) The agency shall investigate the feasibility of~~
2845 ~~developing managed care plan and MediPass options for the~~
2846 ~~following groups of Medicaid recipients:~~
2847 ~~(a) Pregnant women and infants.~~
2848 ~~(b) Elderly and disabled recipients, especially those who~~
2849 ~~are at risk of nursing home placement.~~
2850 ~~(c) Persons with developmental disabilities.~~
2851 ~~(d) Qualified Medicare beneficiaries.~~
2852 ~~(e) Adults who have chronic, high-cost medical conditions.~~
2853 ~~(f) Adults and children who have mental health problems.~~
2854 ~~(g) Other recipients for whom managed care plans and~~
2855 ~~MediPass offer the opportunity of more cost-effective care and~~
2856 ~~greater access to qualified providers.~~

2857 ~~(8)(a) The agency shall encourage the development of~~
2858 ~~public and private partnerships to foster the growth of health~~
2859 ~~maintenance organizations and prepaid health plans that will~~
2860 ~~provide high-quality health care to Medicaid recipients.~~
2861 ~~(b) Subject to the availability of moneys and any~~
2862 ~~limitations established by the General Appropriations Act or~~
2863 ~~chapter 216, the agency is authorized to enter into contracts~~
2864 ~~with traditional providers of health care to low-income persons~~
2865 ~~to assist such providers with the technical aspects of~~
2866 ~~cooperatively developing Medicaid prepaid health plans.~~
2867 ~~1. The agency may contract with disproportionate share~~
2868 ~~hospitals, county health departments, federally initiated or~~
2869 ~~federally funded community health centers, and counties that~~
2870 ~~operate either a hospital or a community clinic.~~
2871 ~~2. A contract may not be for more than $100,000 per year,~~
2872 ~~and no contract may be extended with any particular provider for~~
2873 ~~more than 2 years. The contract is intended only as seed or~~
2874 ~~development funding and requires a commitment from the~~
2875 ~~interested party.~~
2876 ~~3. A contract must require participation by at least one~~
2877 ~~community health clinic and one disproportionate share hospital.~~
2878 <u>(7)</u> ~~(9)~~(a) The agency shall develop and implement a
2879 comprehensive plan to ensure that recipients are adequately
2880 informed of their choices and rights under all Medicaid managed
2881 care programs and that Medicaid managed care programs meet
2882 acceptable standards of quality in patient care, patient
2883 satisfaction, and financial solvency.
2884 (b) The agency shall provide adequate means for informing

2885 patients of their choice and rights under a managed care plan at
2886 the time of eligibility determination.
2887 (c) The agency shall require managed care plans and
2888 MediPass providers to demonstrate and document plans and
2889 activities, as defined by rule, including outreach and followup,
2890 undertaken to ensure that Medicaid recipients receive the health
2891 care service to which they are entitled.
2892
2893 This subsection expires October 1, 2014.
2894 (8) (10) The agency shall consult with Medicaid consumers
2895 and their representatives on an ongoing basis regarding
2896 measurements of patient satisfaction, procedures for resolving
2897 patient grievances, standards for ensuring quality of care,
2898 mechanisms for providing patient access to services, and
2899 policies affecting patient care. This subsection expires
2900 October 1, 2014.
2901 (9) (11) The agency may extend eligibility for Medicaid
2902 recipients enrolled in licensed and accredited health
2903 maintenance organizations for the duration of the enrollment
2904 period or for 6 months, whichever is earlier, provided the
2905 agency certifies that such an offer will not increase state
2906 expenditures. This subsection expires October 1, 2013.
2907 (10) (12) A managed care plan that has a Medicaid contract
2908 shall at least annually review each primary care physician's
2909 active patient load and shall ensure that additional Medicaid
2910 recipients are not assigned to physicians who have a total
2911 active patient load of more than 3,000 patients. As used in this
2912 subsection, the term "active patient" means a patient who is

2913 seen by the same primary care physician, or by a physician
2914 assistant or advanced registered nurse practitioner under the
2915 supervision of the primary care physician, at least three times
2916 within a calendar year. Each primary care physician shall
2917 annually certify to the managed care plan whether or not his or
2918 her patient load exceeds the limits established under this
2919 subsection and the managed care plan shall accept such
2920 certification on face value as compliance with this subsection.
2921 The agency shall accept the managed care plan's representations
2922 that it is in compliance with this subsection based on the
2923 certification of its primary care physicians, unless the agency
2924 has an objective indication that access to primary care is being
2925 compromised, such as receiving complaints or grievances relating
2926 to access to care. If the agency determines that an objective
2927 indication exists that access to primary care is being
2928 compromised, it may verify the patient load certifications
2929 submitted by the managed care plan's primary care physicians and
2930 that the managed care plan is not assigning Medicaid recipients
2931 to primary care physicians who have an active patient load of
2932 more than 3,000 patients. This subsection expires October 1,
2933 2014.
2934 (13) Effective July 1, 2003, the agency shall adjust the
2935 enrollee assignment process of Medicaid managed prepaid health
2936 plans for those Medicaid managed prepaid plans operating in
2937 Miami-Dade County which have executed a contract with the agency
2938 for a minimum of 8 consecutive years in order for the Medicaid
2939 managed prepaid plan to maintain a minimum enrollment level of
2940 15,000 members per month. When assigning enrollees pursuant to

2941 this subsection, the agency shall give priority to providers
2942 that initially qualified under this subsection until such
2943 providers reach and maintain an enrollment level of 15,000
2944 members per month. A prepaid health plan that has a statewide
2945 Medicaid enrollment of 25,000 or more members is not eligible
2946 for enrollee assignments under this subsection. This subsection
2947 expires October 1, 2014.
2948
2949 (11) ~~(14)~~ The agency shall include in its calculation of
2950 the hospital inpatient component of a Medicaid health
2951 maintenance organization's capitation rate any special payments,
2952 including, but not limited to, upper payment limit or
2953 disproportionate share hospital payments, made to qualifying
2954 hospitals through the fee-for-service program. The agency may
2955 seek federal waiver approval or state plan amendment as needed
2956 to implement this adjustment.
2957 (12) The agency shall develop a process to enable any
2958 recipient with access to employer sponsored health care coverage
2959 to opt out of all eligible plans in the Medicaid program and to
2960 use Medicaid financial assistance to pay for the recipient's
2961 share of cost in any such employer-sponsored coverage.
2962 Contingent on federal approval, the agency shall also enable
2963 recipients with access to other insurance or related products
2964 providing access to health care services created pursuant to
2965 state law, including any plan or product available pursuant to
2966 the Florida Health Choices Program or any health exchange, to
2967 opt out. The amount of financial assistance provided for each

2968 recipient shall not exceed the amount of the Medicaid premium
2969 that would have been paid to a plan for that recipient.
2970 (13) The agency shall maintain and operate the Medicaid
2971 Encounter Data System to collect, process, store, and report on
2972 covered services provided to all Florida Medicaid recipients
2973 enrolled in prepaid managed care plans.
2974 (a) Prepaid managed care plans shall submit encounter data
2975 electronically in a format that complies with the Health
2976 Insurance Portability and Accountability Act provisions for
2977 electronic claims and in accordance with deadlines established
2978 by the agency. Prepaid managed care plans must certify that the
2979 data reported is accurate and complete.
2980 (b) The agency is responsible for validating the data
2981 submitted by the plans. The agency shall develop methods and
2982 protocols for ongoing analysis of the encounter data that
2983 adjusts for differences in characteristics of prepaid plan
2984 enrollees to allow comparison of service utilization among plans
2985 and against expected levels of use. The analysis shall be used
2986 to identify possible cases of systemic under-utilization or
2987 denials of claims and inappropriate service utilization such as
2988 higher-than-expected emergency department encounters. The
2989 analysis shall provide periodic feedback to the plans and enable
2990 the agency to establish corrective action plans when necessary.
2991 One of the focus areas for the analysis shall be the use of
2992 prescription drugs.
2993 (14) The agency may establish a per-member per-month
2994 payment for Medicare Advantage Special Needs members that are
2995 also eligible for Medicaid as a mechanism for meeting the

2996 state's cost sharing obligation. The agency may also develop a
2997 per-member per-month payment for Medicaid only covered services
2998 for which the state is responsible. The agency shall develop a
2999 mechanism to ensure that such per-member per-month payment
3000 enhances the value to the state and enrolled members by limiting
3001 cost sharing, enhancing the scope of Medicare supplemental
3002 benefits that are equal to or greater than Medicaid coverage for
3003 select services, and improving care coordination.
3004 (15) The agency shall establish, and managed care plans
3005 shall use, a uniform method of accounting for and reporting
3006 medical and nonmedical costs. The agency shall make such
3007 information available to the public.
3008 (16) The agency may, on a case-by-case basis, exempt a
3009 recipient from mandatory enrollment in a managed care plan when
3010 the recipient has a unique, time-limited disease or condition-
3011 related circumstance and managed care enrollment will interfere
3012 with ongoing care because the recipient's provider does not
3013 participate in the managed care plans available in the
3014 recipient's area.
3015 (17) The agency shall contract with a single provider
3016 service network to function as a third party administrator and
3017 managing entity for the MediPass program in all counties with
3018 less two prepaid plans. The contractor may earn an
3019 administrative fee, provided that fee is less than any savings
3020 determined by the reconciliation process pursuant to s.
3021 409.912(4)(d)(1). This subsection shall expire October 1, 2014
3022 or upon full implementation of the managed medical assistance
3023 program whichever is sooner.

3024 Section 16. Subsection (15) of section 430.04, Florida
3025 Statutes, is amended to read:
3026 430.04 Duties and responsibilities of the Department of
3027 Elderly Affairs.—The Department of Elderly Affairs shall:
3028 (15) Administer all Medicaid waivers and programs relating
3029 to elders and their appropriations. The waivers include, but are
3030 not limited to:
3031 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~
3032 ~~established in s. 430.502(7), (8), and (9).~~
3033 (a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.
3034 (b) ~~(c)~~ The Aged and Disabled Adult Waiver.
3035 (c) ~~(d)~~ The Adult Day Health Care Waiver.
3036 (d) ~~(e)~~ The Consumer-Directed Care Plus Program as
3037 defined in s. 409.221.
3038 (e) ~~(f)~~ The Program of All-inclusive Care for the
3039 Elderly.
3040 (f) ~~(g)~~ The Long-Term Care Community-Based Diversion
3041 Pilot Project as described in s. 430.705.
3042 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.
3043
3044 The department shall develop a transition plan for recipients
3045 receiving services in long-term care Medicaid waivers for elders
3046 or disabled adults on the date eligible plans become available
3047 in each recipient's region defined in s. 409.981(2) to enroll
3048 those recipients in eligible plans. This subsection expires
3049 October 1, 2013.
3050

3051 Section 17. Section 430.2053, Florida Statutes, is amended
3052 to read:
3053 430.2053 Aging resource centers.—
3054 (1) The department, in consultation with the Agency for
3055 Health Care Administration and the Department of Children and
3056 Family Services, shall develop pilot projects for aging resource
3057 centers. ~~By October 31, 2004, the department, in consultation~~
3058 ~~with the agency and the Department of Children and Family~~
3059 ~~Services, shall develop an implementation plan for aging~~
3060 ~~resource centers and submit the plan to the Governor, the~~
3061 ~~President of the Senate, and the Speaker of the House of~~
3062 ~~Representatives. The plan must include qualifications for~~
3063 ~~designation as a center, the functions to be performed by each~~
3064 ~~center, and a process for determining that a current area agency~~
3065 ~~on aging is ready to assume the functions of an aging resource~~
3066 ~~center.~~
3067 ~~(2) Each area agency on aging shall develop, in~~
3068 ~~consultation with the existing community care for the elderly~~
3069 ~~lead agencies within their planning and service areas, a~~
3070 ~~proposal that describes the process the area agency on aging~~
3071 ~~intends to undertake to transition to an aging resource center~~
3072 ~~prior to July 1, 2005, and that describes the area agency's~~
3073 ~~compliance with the requirements of this section. The proposals~~
3074 ~~must be submitted to the department prior to December 31, 2004.~~
3075 ~~The department shall evaluate all proposals for readiness and,~~
3076 ~~prior to March 1, 2005, shall select three area agencies on~~
3077 ~~aging which meet the requirements of this section to begin the~~
3078 ~~transition to aging resource centers. Those area agencies on~~

3079 aging which are not selected to begin the transition to aging
3080 resource centers shall, in consultation with the department and
3081 the existing community care for the elderly lead agencies within
3082 their planning and service areas, amend their proposals as
3083 necessary and resubmit them to the department prior to July 1,
3084 2005. The department may transition additional area agencies to
3085 aging resource centers as it determines that area agencies are
3086 in compliance with the requirements of this section.
3087 (3) The Auditor General and the Office of Program Policy
3088 Analysis and Government Accountability (OPPAGA) shall jointly
3089 review and assess the department's process for determining an
3090 area agency's readiness to transition to an aging resource
3091 center.
3092 (a) The review must, at a minimum, address the
3093 appropriateness of the department's criteria for selection of an
3094 area agency to transition to an aging resource center, the
3095 instruments applied, the degree to which the department
3096 accurately determined each area agency's compliance with the
3097 readiness criteria, the quality of the technical assistance
3098 provided by the department to an area agency in correcting any
3099 weaknesses identified in the readiness assessment, and the
3100 degree to which each area agency overcame any identified
3101 weaknesses.
3102 (b) Reports of these reviews must be submitted to the
3103 appropriate substantive and appropriations committees in the
3104 Senate and the House of Representatives on March 1 and September
3105 1 of each year until full transition to aging resource centers
3106 has been accomplished statewide, except that the first report

3107 ~~must be submitted by February 1, 2005, and must address all~~
3108 ~~readiness activities undertaken through December 31, 2004. The~~
3109 ~~perspectives of all participants in this review process must be~~
3110 ~~included in each report.~~
3111 (2) ~~(4)~~ The purposes of an aging resource center shall
3112 be:
3113 (a) To provide Florida's elders and their families with a
3114 locally focused, coordinated approach to integrating information
3115 and referral for all available services for elders with the
3116 eligibility determination entities for state and federally
3117 funded long-term-care services.
3118 (b) To provide for easier access to long-term-care
3119 services by Florida's elders and their families by creating
3120 multiple access points to the long-term-care network that flow
3121 through one established entity with wide community recognition.
3122 (3) ~~(5)~~ The duties of an aging resource center are to:
3123 (a) Develop referral agreements with local community
3124 service organizations, such as senior centers, existing elder
3125 service providers, volunteer associations, and other similar
3126 organizations, to better assist clients who do not need or do
3127 not wish to enroll in programs funded by the department or the
3128 agency. The referral agreements must also include a protocol,
3129 developed and approved by the department, which provides
3130 specific actions that an aging resource center and local
3131 community service organizations must take when an elder or an
3132 elder's representative seeking information on long-term-care
3133 services contacts a local community service organization prior
3134 to contacting the aging resource center. The protocol shall be

3135 designed to ensure that elders and their families are able to
3136 access information and services in the most efficient and least
3137 cumbersome manner possible.
3138 (b) Provide an initial screening of all clients who
3139 request long-term-care services to determine whether the person
3140 would be most appropriately served through any combination of
3141 federally funded programs, state-funded programs, locally funded
3142 or community volunteer programs, or private funding for
3143 services.
3144 (c) Determine eligibility for the programs and services
3145 listed in subsection (9) ~~(11)~~ for persons residing within the
3146 geographic area served by the aging resource center and
3147 determine a priority ranking for services which is based upon
3148 the potential recipient's frailty level and likelihood of
3149 institutional placement without such services.
3150 (d) Manage the availability of financial resources for the
3151 programs and services listed in subsection (11) for persons
3152 residing within the geographic area served by the aging resource
3153 center.
3154 (e) When financial resources become available, refer a
3155 client to the most appropriate entity to begin receiving
3156 services. The aging resource center shall make referrals to lead
3157 agencies for service provision that ensure that individuals who
3158 are vulnerable adults in need of services pursuant to s.
3159 415.104(3)(b), or who are victims of abuse, neglect, or
3160 exploitation in need of immediate services to prevent further
3161 harm and are referred by the adult protective services program,
3162 are given primary consideration for receiving community-care-

3163 for-the-elderly services in compliance with the requirements of
3164 s. 430.205(5)(a) and that other referrals for services are in
3165 compliance with s. 430.205(5)(b).
3166 (f) Convene a work group to advise in the planning,
3167 implementation, and evaluation of the aging resource center. The
3168 work group shall be comprised of representatives of local
3169 service providers, Alzheimer's Association chapters, housing
3170 authorities, social service organizations, advocacy groups,
3171 representatives of clients receiving services through the aging
3172 resource center, and any other persons or groups as determined
3173 by the department. The aging resource center, in consultation
3174 with the work group, must develop annual program improvement
3175 plans that shall be submitted to the department for
3176 consideration. The department shall review each annual
3177 improvement plan and make recommendations on how to implement
3178 the components of the plan.
3179 (g) Enhance the existing area agency on aging in each
3180 planning and service area by integrating, either physically or
3181 virtually, the staff and services of the area agency on aging
3182 with the staff of the department's local CARES Medicaid ~~nursing~~
3183 ~~home~~ preadmission screening unit and a sufficient number of
3184 staff from the Department of Children and Family Services'
3185 Economic Self-Sufficiency Unit necessary to determine the
3186 financial eligibility for all persons age 60 and older residing
3187 within the area served by the aging resource center that are
3188 seeking Medicaid services, Supplemental Security Income, and
3189 food assistance.
3190 <u>(h) Assist clients who request long-term care services in</u>

3191 being evaluated for eligibility for enrollment in the Medicaid
3192 long-term care managed care program as eligible plans become
3193 available in each of the regions pursuant to s. 409.981(2).
3194 (i) Provide choice counseling for the Medicaid long-term
3195 care managed care program by integrating, either physically or
3196 virtually, choice counseling staff and services as eligible
3197 plans become available in each of the regions pursuant to s.
3198 409.981(2). Pursuant to s. 409.984(1), the agency may contract
3199 directly with the aging resource center to provide choice
3200 counseling services or may contract with another vendor if the
3201 aging resource center does not choose to provide such services.
3202 (j) Assist Medicaid recipients enrolled in the Medicaid
3203 long-term care managed care program with informally resolving
3204 grievances with a managed care network and assist Medicaid
3205 recipients in accessing the managed care network's formal
3206 grievance process as eligible plans become available in each of
3207 the regions defined in s. 409.981(2).
3208 (4) ~~(6)~~ The department shall select the entities to
3209 become aging resource centers based on each entity's readiness
3210 and ability to perform the duties listed in subsection (3) ~~(5)~~
3211 and the entity's:
3212 (a) Expertise in the needs of each target population the
3213 center proposes to serve and a thorough knowledge of the
3214 providers that serve these populations.
3215 (b) Strong connections to service providers, volunteer
3216 agencies, and community institutions.
3217 (c) Expertise in information and referral activities.
3218 (d) Knowledge of long-term-care resources, including

3219 resources designed to provide services in the least restrictive
3220 setting.
3221 (e) Financial solvency and stability.
3222 (f) Ability to collect, monitor, and analyze data in a
3223 timely and accurate manner, along with systems that meet the
3224 department's standards.
3225 (g) Commitment to adequate staffing by qualified personnel
3226 to effectively perform all functions.
3227 (h) Ability to meet all performance standards established
3228 by the department.
3229 (5) ~~(7)~~ The aging resource center shall have a governing
3230 body which shall be the same entity described in s. 20.41(7),
3231 and an executive director who may be the same person as
3232 described in s. 20.41(7). The governing body shall annually
3233 evaluate the performance of the executive director.
3234 (6) ~~(8)~~ The aging resource center may not be a provider
3235 of direct services other than choice counseling as eligible
3236 plans become available in each of the regions defined in s.
3237 409.981(2), information and referral services, and screening.
3238 (7) ~~(9)~~ The aging resource center must agree to allow the
3239 department to review any financial information the department
3240 determines is necessary for monitoring or reporting purposes,
3241 including financial relationships.
3242 (8) ~~(10)~~ The duties and responsibilities of the community
3243 care for the elderly lead agencies within each area served by an
3244 aging resource center shall be to:
3245 (a) Develop strong community partnerships to maximize the
3246 use of community resources for the purpose of assisting elders

3247 to remain in their community settings for as long as it is
3248 safely possible.
3249 (b) Conduct comprehensive assessments of clients that have
3250 been determined eligible and develop a care plan consistent with
3251 established protocols that ensures that the unique needs of each
3252 client are met.
3253 (9) ~~(11)~~ The services to be administered through the
3254 aging resource center shall include those funded by the
3255 following programs:
3256 (a) Community care for the elderly.
3257 (b) Home care for the elderly.
3258 (c) Contracted services.
3259 (d) Alzheimer's disease initiative.
3260 (e) Aged and disabled adult Medicaid waiver. This
3261 paragraph expires October 1, 2013.
3262 (f) Assisted living for the frail elderly Medicaid waiver.
3263 This paragraph expires October 1, 2013.
3264 (g) Older Americans Act.
3265 (10) ~~(12)~~ The department shall, prior to designation of an
3266 aging resource center, develop by rule operational and quality
3267 assurance standards and outcome measures to ensure that clients
3268 receiving services through all long-term-care programs
3269 administered through an aging resource center are receiving the
3270 appropriate care they require and that contractors and
3271 subcontractors are adhering to the terms of their contracts and
3272 are acting in the best interests of the clients they are
3273 serving, consistent with the intent of the Legislature to reduce
3274 the use of and cost of nursing home care. The department shall

3275 by rule provide operating procedures for aging resource centers,
3276 which shall include:
3277 (a) Minimum standards for financial operation, including
3278 audit procedures.
3279 (b) Procedures for monitoring and sanctioning of service
3280 providers.
3281 (c) Minimum standards for technology utilized by the aging
3282 resource center.
3283 (d) Minimum staff requirements which shall ensure that the
3284 aging resource center employs sufficient quality and quantity of
3285 staff to adequately meet the needs of the elders residing within
3286 the area served by the aging resource center.
3287 (e) Minimum accessibility standards, including hours of
3288 operation.
3289 (f) Minimum oversight standards for the governing body of
3290 the aging resource center to ensure its continuous involvement
3291 in, and accountability for, all matters related to the
3292 development, implementation, staffing, administration, and
3293 operations of the aging resource center.
3294 (g) Minimum education and experience requirements for
3295 executive directors and other executive staff positions of aging
3296 resource centers.
3297 (h) Minimum requirements regarding any executive staff
3298 positions that the aging resource center must employ and minimum
3299 requirements that a candidate must meet in order to be eligible
3300 for appointment to such positions.
3301 (11) ~~(13)~~ In an area in which the department has
3302 designated an area agency on aging as an aging resource center,

3303 the department and the agency shall not make payments for the
3304 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
3305 Community Diversion Project for such persons who were not
3306 screened and enrolled through the aging resource center. The
3307 department shall cease making payments for recipients in
3308 eligible plans as eligible plans become available in each of the
3309 regions defined in s. 409.981(2).
3310 (12) ~~(14)~~ Each aging resource center shall enter into a
3311 memorandum of understanding with the department for
3312 collaboration with the CARES unit staff. The memorandum of
3313 understanding shall outline the staff person responsible for
3314 each function and shall provide the staffing levels necessary to
3315 carry out the functions of the aging resource center.
3316 (13) ~~(15)~~ Each aging resource center shall enter into a
3317 memorandum of understanding with the Department of Children and
3318 Family Services for collaboration with the Economic Self-
3319 Sufficiency Unit staff. The memorandum of understanding shall
3320 outline which staff persons are responsible for which functions
3321 and shall provide the staffing levels necessary to carry out the
3322 functions of the aging resource center.
3323 (14) As eligible plans become available in each of the
3324 regions defined in s. 409.981(2), if an aging resource center
3325 does not contract with the agency to provide Medicaid long-term
3326 care managed care choice counseling pursuant to s. 409.984(1),
3327 the aging resource center shall enter into a memorandum of
3328 understanding with the agency to coordinate staffing and
3329 collaborate with the choice counseling vendor. The memorandum of
3330 understanding shall identify the staff responsible for each

3331 function and shall provide the staffing levels necessary to
3332 carry out the functions of the aging resource center.
3333 (15) ~~(16)~~ If any of the state activities described in this
3334 section are outsourced, either in part or in whole, the contract
3335 executing the outsourcing shall mandate that the contractor or
3336 its subcontractors shall, either physically or virtually,
3337 execute the provisions of the memorandum of understanding
3338 instead of the state entity whose function the contractor or
3339 subcontractor now performs.
3340 (16) ~~(17)~~ In order to be eligible to begin transitioning
3341 to an aging resource center, an area agency on aging board must
3342 ensure that the area agency on aging which it oversees meets all
3343 of the minimum requirements set by law and in rule.
3344 ~~(18) The department shall monitor the three initial~~
3345 ~~projects for aging resource centers and report on the progress~~
3346 ~~of those projects to the Governor, the President of the Senate,~~
3347 ~~and the Speaker of the House of Representatives by June 30,~~
3348 ~~2005. The report must include an evaluation of the~~
3349 ~~implementation process.~~
3350 (17) ~~(19)~~(a) Once an aging resource center is operational,
3351 the department, in consultation with the agency, may develop
3352 capitation rates for any of the programs administered through
3353 the aging resource center. Capitation rates for programs shall
3354 be based on the historical cost experience of the state in
3355 providing those same services to the population age 60 or older
3356 residing within each area served by an aging resource center.
3357 Each capitated rate may vary by geographic area as determined by
3358 the department.

3359 (b) The department and the agency may determine for each
3360 area served by an aging resource center whether it is
3361 appropriate, consistent with federal and state laws and
3362 regulations, to develop and pay separate capitated rates for
3363 each program administered through the aging resource center or
3364 to develop and pay capitated rates for service packages which
3365 include more than one program or service administered through
3366 the aging resource center.
3367 (c) Once capitation rates have been developed and
3368 certified as actuarially sound, the department and the agency
3369 may pay service providers the capitated rates for services when
3370 appropriate.
3371 (d) The department, in consultation with the agency, shall
3372 annually reevaluate and recertify the capitation rates,
3373 adjusting forward to account for inflation, programmatic
3374 changes.
3375 ~~(20) The department, in consultation with the agency,~~
3376 ~~shall submit to the Governor, the President of the Senate, and~~
3377 ~~the Speaker of the House of Representatives, by December 1,~~
3378 ~~2006, a report addressing the feasibility of administering the~~
3379 ~~following services through aging resource centers beginning July~~
3380 ~~1, 2007:~~
3381 ~~(a) Medicaid nursing home services.~~
3382 ~~(b) Medicaid transportation services.~~
3383 ~~(c) Medicaid hospice care services.~~
3384 ~~(d) Medicaid intermediate care services.~~
3385 ~~(e) Medicaid prescribed drug services.~~
3386 ~~(f) Medicaid assistive care services.~~

3387 ~~(g) Any other long-term-care program or Medicaid service.~~
3388 (18) ~~(21)~~ This section shall not be construed to allow an
3389 aging resource center to restrict, manage, or impede the local
3390 fundraising activities of service providers.
3391 Section 18. Subsection (4) of section 641.386, Florida
3392 Statutes, is amended to read:
3393 641.386 Agent licensing and appointment required;
3394 exceptions.—
3395 (4) All agents and health maintenance organizations shall
3396 comply with and be subject to the applicable provisions of ss.
3397 641.309 and 409.912 (20) ~~(21)~~, and all companies and entities
3398 appointing agents shall comply with s. 626.451, when marketing
3399 for any health maintenance organization licensed pursuant to
3400 this part, including those organizations under contract with the
3401 Agency for Health Care Administration to provide health care
3402 services to Medicaid recipients or any private entity providing
3403 health care services to Medicaid recipients pursuant to a
3404 prepaid health plan contract with the Agency for Health Care
3405 Administration.
3406 Section 19. Effective October 1, 2013, sections 430.701,
3407 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707,
3408 430.708, and 430.709 Florida Statutes, are repealed.
3409 Section 20. Sections 409.9301, 409.942, 409.944, 409.945,
3410 409.946, 409.953, and 409.9531, Florida Statutes, are renumbered
3411 as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
3412 402.87, Florida Statutes, respectively.
3413 Section 21. Paragraph (a) of subsection (1) of section
3414 443.111, Florida Statutes, is amended to read:

3415 443.111 Payment of benefits.—
3416 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
3417 in accordance with rules adopted by the Agency for Workforce
3418 Innovation, subject to the following requirements:
3419 (a) Benefits are payable by mail or electronically.
3420 Notwithstanding s. 402.84(4) ~~s. 409.942(4)~~, the agency may
3421 develop a system for the payment of benefits by electronic funds
3422 transfer, including, but not limited to, debit cards, electronic
3423 payment cards, or any other means of electronic payment that the
3424 agency deems to be commercially viable or cost-effective.
3425 Commodities or services related to the development of such a
3426 system shall be procured by competitive solicitation, unless
3427 they are purchased from a state term contract pursuant to s.
3428 287.056. The agency shall adopt rules necessary to administer
3429 the system.
3430 Section 22. The Agency for Health Care Administration
3431 shall develop a plan for implementing s. 409.975(8) and shall
3432 immediately seek federal approval to implement the subsection.
3433 The plan shall include a preliminary calculation of actuarially
3434 sound rates and estimated fiscal impact.
3435 Section 23. Except as otherwise expressly provided in this
3436 act, this act shall take effect July 1, 2011, if PCB HHSC 11-01
3437 or similar legislation is adopted in the same legislative
3438 session or an extension thereof and becomes law.