1 A bill to be entitled
2 An act relating to health care; transferring and
3 reassigning certain functions and responsibilities,
4 including records, personnel, property, and unexpended
5 balances of appropriations and other resources, from the
6 Department of Health to the Department of Business and
7 Professional Regulation by a type two transfer; providing
8 for the continued validity of pending judicial or
9 administrative actions to which the Department of Health
10 is a party; providing for the continued validity of lawful
11 orders issued by the Department of Health; transferring
12 rules created by the Department of Health to the
13 Department of Business and Professional Regulation;
14 providing for the continued validity of permits and
15 certifications issued by the Department of Health;
16 amending s. 400.179, F.S.; authorizing the Agency for
17 Health Care Administration to transfer funds to the Grants
18 and Donations Trust Fund for certain repayments; amending
19 s. 400.23, F.S.; providing minimum staffing requirements
20 for nursing homes for a specified period; amending s.
21 409.905, F.S.; eliminating authority for certain hospital
22 inpatient per diem rate adjustment; amending s. 409.906,
23 F.S.; prohibiting payment for Medicaid chiropractic
24 services, hospice care services, and podiatric services
25 for 2 fiscal years; authorizing payment of a specified
26 amount for Medicaid services provided by an
27 anesthesiologist assistant; amending s. 409.908, F.S.;
28 deleting a provision prohibiting Medicaid from making any

29 payment toward deductibles and coinsurance for services
30 not covered by Medicaid; providing limitations on Medicaid
31 payments for coinsurance; revising reimbursement rates for
32 providers of Medicaid prescribed drugs; requiring the
33 agency to continue collecting but suspend the use of cost
34 data to set reimbursement rates for hospitals, nursing
35 homes, county health departments, and community
36 intermediate care facilities for the developmentally
37 disabled for 2 fiscal years; requiring the agency to apply
38 the effect of the suspension of the use of cost data to
39 set reimbursement rates for managed care plans and nursing
40 home diversion programs; requiring the agency to establish
41 workgroups to evaluate alternative reimbursement and
42 payment methodologies for hospitals, nursing facilities,
43 and managed care plans; requiring a report; providing for
44 future repeal of the suspension of the use of cost data to
45 set certain rates; amending s. 409.911, F.S.; revising the
46 share data used to calculate disproportionate share
47 payments to hospitals; amending s. 409.9112, F.S.;
48 revising the time period during which the agency is
49 prohibited from distributing disproportionate share
50 payments to regional perinatal intensive care centers;
51 amending s. 409.9113, F.S.; requiring the agency to
52 distribute moneys provided in the General Appropriations
53 Act to statutorily defined teaching hospitals and family
54 practice teaching hospitals under the teaching hospital
55 disproportionate share program for the 2008-2009 fiscal
56 year; amending s. 409.9117, F.S.; prohibiting the agency

57 from distributing moneys under the primary care
58 disproportionate share program for the 2008-2009 fiscal
59 year; amending s. 409.912, F.S.; revising reimbursement
60 rates to pharmacies for Medicaid prescribed drugs;
61 requiring the agency to notify the Legislature before
62 seeking an amendment to the state plan in order to
63 implement programs authorized by the Deficit Reduction Act
64 of 2005; amending s. 409.91211, F.S.; providing for
65 expansion of the Medicaid managed care pilot program to
66 Miami-Dade, Monroe, Pasco, Pinellas, Hardee, Highlands,
67 Hillsborough, Manatee, and Polk Counties; permitting fee-
68 for-service provider service networks to be reimbursed on
69 a risk-adjusted capitated basis for certain services;
70 requiring the agency to encourage cost-effective
71 administration by provider service networks; requiring
72 quarterly monitoring and annual evaluation of plan network
73 adequacy; requiring that Medicaid recipients receive
74 prescription drug coverage information for each plan;
75 requiring the agency to set standards for prompt claims
76 payment; revising assignment processes for certain
77 recipients; amending s. 409.9124, F.S.; removing the
78 limitation on the application of certain rates and rate
79 reductions used by the agency to reimburse managed care
80 plans; amending s. 409.913, F.S.; prohibiting mailing of
81 the explanation of benefits for certain Medicaid services;
82 repealing s. 381.0271, F.S., relating to the Florida
83 Patient Safety Corporation; repealing s. 381.0273, F.S.,
84 relating to public records exemption for patient safety

85 data; repealing s. 394.4595, F.S., relating to access to
86 patient records by the Florida statewide and local
87 advocacy councils; repealing s. 402.164, F.S., relating to
88 the Florida Statewide Advocacy Council and the Florida
89 local advocacy councils; repealing s. 402.165, F.S.,
90 relating to the Florida Statewide Advocacy Council;
91 repealing s. 402.166, F.S., relating to Florida local
92 advocacy councils; repealing s. 402.167, F.S., relating to
93 duties of state agencies that provide client services
94 relating to the Florida Statewide Advocacy Council and the
95 Florida local advocacy councils; repealing s. 409.9061,
96 F.S., relating to authority for a statewide laboratory
97 services contract; repealing s. 430.80, F.S., relating to
98 implementation of a teaching nursing home pilot project;
99 repealing s. 430.83, F.S., relating to the Sunshine for
100 Seniors Program; repealing ss. 464.0195, 464.0196, and
101 464.0197, F.S., relating to the Florida Center for
102 Nursing; repealing s. 464.0198, F.S., relating to the
103 Florida Center for Nursing Trust Fund; amending ss.
104 39.001, 39.0011, 39.202, 39.302, 215.22, 394.459,
105 394.4597, 394.4598, 394.4599, 394.4615, 400.0065, 400.118,
106 400.141, 415.1034, 415.104, 415.1055, 415.106, 415.107,
107 429.19, 429.28, 429.34, and 430.04, F.S.; conforming
108 provisions and correcting cross-references; providing an
109 effective date.
110
111 Be It Enacted by the Legislature of the State of Florida:
112

113 Section 1. (1) Effective April 1, 2009, all of the
114 statutory powers, duties and functions, records, personnel,
115 property, and unexpended balances of appropriations,
116 allocations, or other funds for the administration of part I of
117 chapter 499, Florida Statutes, relating to drugs, devices,
118 cosmetics, and household products shall be transferred by a type
119 two transfer, as defined in s. 20.06(2), Florida Statutes, from
120 the Department of Health to the Department of Business and
121 Professional Regulation.
122 (2) The transfer of regulatory authority under part I of
123 chapter 499, Florida Statutes, provided by this act shall not
124 affect the validity of any judicial or administrative action
125 pending as of 11:59 p.m. on the day before the effective date of
126 this act to which the Department of Health is at that time a
127 party, and the Department of Business and Professional
128 Regulation shall be substituted as a party in interest in any
129 such action.
130 (3) All lawful orders issued by the Department of Health
131 implementing or enforcing or otherwise in regard to any
132 provision of part I of chapter 499, Florida Statutes, issued
133 prior to the effective date of this act shall remain in effect
134 and be enforceable after the effective date of this act unless
135 thereafter modified in accordance with law.
136 (4) The rules of the Department of Health relating to the
137 implementation of part I of chapter 499, Florida Statutes, that
138 were in effect at 11:59 p.m. on the day prior to this act taking
139 effect shall become the rules of the Department of Business and

140 Professional Regulation and shall remain in effect until amended
141 or repealed in the manner provided by law.
142 (5) Notwithstanding the transfer of regulatory authority
143 under part I of chapter 499, Florida Statutes, provided by this
144 act, persons and entities holding in good standing any permit
145 under part I of chapter 499, Florida Statutes, as of 11:59 p.m.
146 on the day prior to the effective date of this act shall, as of
147 the effective date of this act, be deemed to hold in good
148 standing a permit in the same capacity as that for which the
149 permit was formerly issued.
150 (6) Notwithstanding the transfer of regulatory authority
151 under part I of chapter 499, Florida Statutes, provided by this
152 act, persons holding in good standing any certification under
153 part I of chapter 499, Florida Statutes, as of 11:59 p.m. on the
154 day prior to the effective date of this act shall, as of the
155 effective date of this act, be deemed to be certified in the
156 same capacity in which they were formerly certified.
157 Section 2. Paragraph (d) of subsection (2) of section
158 400.179, Florida Statutes, is amended to read:
159 400.179 Liability for Medicaid underpayments and
160 overpayments.--
161 (2) Because any transfer of a nursing facility may expose
162 the fact that Medicaid may have underpaid or overpaid the
163 transferor, and because in most instances, any such underpayment
164 or overpayment can only be determined following a formal field
165 audit, the liabilities for any such underpayments or
166 overpayments shall be as follows:

167 (d) Where the transfer involves a facility that has been
168 leased by the transferor:
169 1. The transferee shall, as a condition to being issued a
170 license by the agency, acquire, maintain, and provide proof to
171 the agency of a bond with a term of 30 months, renewable
172 annually, in an amount not less than the total of 3 months'
173 Medicaid payments to the facility computed on the basis of the
174 preceding 12-month average Medicaid payments to the facility.
175 2. A leasehold licensee may meet the requirements of
176 subparagraph 1. by payment of a nonrefundable fee, paid at
177 initial licensure, paid at the time of any subsequent change of
178 ownership, and paid annually thereafter, in the amount of 1
179 percent of the total of 3 months' Medicaid payments to the
180 facility computed on the basis of the preceding 12-month average
181 Medicaid payments to the facility. If a preceding 12-month
182 average is not available, projected Medicaid payments may be
183 used. The fee shall be deposited into the Health Care Trust Fund
184 and shall be accounted for separately as a Medicaid nursing home
185 overpayment account. These fees shall be used at the sole
186 discretion of the agency to repay nursing home Medicaid
187 overpayments. The agency is authorized to transfer funds to the
188 Grants and Donations Trust Fund for such repayments. Payment of
189 this fee shall not release the licensee from any liability for
190 any Medicaid overpayments, nor shall payment bar the agency from
191 seeking to recoup overpayments from the licensee and any other
192 liable party. As a condition of exercising this lease bond
193 alternative, licensees paying this fee must maintain an existing
194 lease bond through the end of the 30-month term period of that

195 bond. The agency is herein granted specific authority to
196 promulgate all rules pertaining to the administration and
197 management of this account, including withdrawals from the
198 account, subject to federal review and approval. This provision
199 shall take effect upon becoming law and shall apply to any
200 leasehold license application. The financial viability of the
201 Medicaid nursing home overpayment account shall be determined by
202 the agency through annual review of the account balance and the
203 amount of total outstanding, unpaid Medicaid overpayments owing
204 from leasehold licensees to the agency as determined by final
205 agency audits.
206 3. The leasehold licensee may meet the bond requirement
207 through other arrangements acceptable to the agency. The agency
208 is herein granted specific authority to promulgate rules
209 pertaining to lease bond arrangements.
210 4. All existing nursing facility licensees, operating the
211 facility as a leasehold, shall acquire, maintain, and provide
212 proof to the agency of the 30-month bond required in
213 subparagraph 1., above, on and after July 1, 1993, for each
214 license renewal.
215 5. It shall be the responsibility of all nursing facility
216 operators, operating the facility as a leasehold, to renew the
217 30-month bond and to provide proof of such renewal to the agency
218 annually.
219 6. Any failure of the nursing facility operator to
220 acquire, maintain, renew annually, or provide proof to the
221 agency shall be grounds for the agency to deny, revoke, and
222 suspend the facility license to operate such facility and to

223 take any further action, including, but not limited to,
224 enjoining the facility, asserting a moratorium pursuant to part
225 II of chapter 408, or applying for a receiver, deemed necessary
226 to ensure compliance with this section and to safeguard and
227 protect the health, safety, and welfare of the facility's
228 residents. A lease agreement required as a condition of bond
229 financing or refinancing under s. 154.213 by a health facilities
230 authority or required under s. 159.30 by a county or
231 municipality is not a leasehold for purposes of this paragraph
232 and is not subject to the bond requirement of this paragraph.
233 Section 3. Paragraph (a) of subsection (3) of section
234 400.23, Florida Statutes, is amended to read:
235 400.23 Rules; evaluation and deficiencies; licensure
236 status.--
237 (3)(a)1. The agency shall adopt rules providing minimum
238 staffing requirements for nursing homes. These requirements
239 shall include, for each nursing home facility:
240 a. A minimum certified nursing assistant staffing of 2.6
241 hours of direct care per resident per day beginning January 1,
242 2003, and increasing to 2.7 hours of direct care per resident
243 per day beginning January 1, 2007. Beginning January 1, 2002, no
244 facility shall staff below one certified nursing assistant per
245 20 residents, and a minimum licensed nursing staffing of 1.0
246 hour of direct care per resident per day but never below one
247 licensed nurse per 40 residents.
248 b. Beginning January 1, 2007, a minimum weekly average
249 certified nursing assistant staffing of 2.9 hours of direct care

250 per resident per day. For the purpose of this sub-subparagraph,
251 a week is defined as Sunday through Saturday.
252 c. Beginning July 1, 2008, and ending June 30, 2010, a
253 minimum daily combined average certified nursing assistant and
254 licensed nursing staffing of 3.7 hours of direct care per
255 resident per day, with a minimum certified nursing assistant
256 staffing of 2.6 hours of direct care per resident per day and a
257 minimum licensed nursing staffing of 1.0 hour of direct care per
258 resident per day. No facility shall staff below one certified
259 nursing assistant per 20 residents and one licensed nurse per 40
260 residents.
261 2. Nursing assistants employed under s. 400.211(2) may be
262 included in computing the staffing ratio for certified nursing
263 assistants only if their job responsibilities include only
264 nursing-assistant-related duties.
265 3. Each nursing home must document compliance with
266 staffing standards as required under this paragraph and post
267 daily the names of staff on duty for the benefit of facility
268 residents and the public.
269 4. The agency shall recognize the use of licensed nurses
270 for compliance with minimum staffing requirements for certified
271 nursing assistants, provided that the facility otherwise meets
272 the minimum staffing requirements for licensed nurses and that
273 the licensed nurses are performing the duties of a certified
274 nursing assistant. Unless otherwise approved by the agency,
275 licensed nurses counted toward the minimum staffing requirements
276 for certified nursing assistants must exclusively perform the
277 duties of a certified nursing assistant for the entire shift and

278 not also be counted toward the minimum staffing requirements for
279 licensed nurses. If the agency approved a facility's request to
280 use a licensed nurse to perform both licensed nursing and
281 certified nursing assistant duties, the facility must allocate
282 the amount of staff time specifically spent on certified nursing
283 assistant duties for the purpose of documenting compliance with
284 minimum staffing requirements for certified and licensed nursing
285 staff. In no event may the hours of a licensed nurse with dual
286 job responsibilities be counted twice.
287 Section 4. Paragraphs (d) and (e) of subsection (5) of
288 section 409.905, Florida Statutes, are redesignated as
289 paragraphs (c) and (d), respectively, and present paragraph (c)
290 of that subsection is amended to read:
291 409.905 Mandatory Medicaid services.--The agency may make
292 payments for the following services, which are required of the
293 state by Title XIX of the Social Security Act, furnished by
294 Medicaid providers to recipients who are determined to be
295 eligible on the dates on which the services were provided. Any
296 service under this section shall be provided only when medically
297 necessary and in accordance with state and federal law.
298 Mandatory services rendered by providers in mobile units to
299 Medicaid recipients may be restricted by the agency. Nothing in
300 this section shall be construed to prevent or limit the agency
301 from adjusting fees, reimbursement rates, lengths of stay,
302 number of visits, number of services, or any other adjustments
303 necessary to comply with the availability of moneys and any
304 limitations or directions provided for in the General
305 Appropriations Act or chapter 216.

306 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for
307 all covered services provided for the medical care and treatment
308 of a recipient who is admitted as an inpatient by a licensed
309 physician or dentist to a hospital licensed under part I of
310 chapter 395. However, the agency shall limit the payment for
311 inpatient hospital services for a Medicaid recipient 21 years of
312 age or older to 45 days or the number of days necessary to
313 comply with the General Appropriations Act.
314 ~~(c) The Agency for Health Care Administration shall adjust~~
315 ~~a hospital's current inpatient per diem rate to reflect the cost~~
316 ~~of serving the Medicaid population at that institution if:~~
317 ~~1. The hospital experiences an increase in Medicaid~~
318 ~~caseload by more than 25 percent in any year, primarily~~
319 ~~resulting from the closure of a hospital in the same service~~
320 ~~area occurring after July 1, 1995;~~
321 ~~2. The hospital's Medicaid per diem rate is at least 25~~
322 ~~percent below the Medicaid per patient cost for that year; or~~
323 ~~3. The hospital is located in a county that has five or~~
324 ~~fewer hospitals, began offering obstetrical services on or after~~
325 ~~September 1999, and has submitted a request in writing to the~~
326 ~~agency for a rate adjustment after July 1, 2000, but before~~
327 ~~September 30, 2000, in which case such hospital's Medicaid~~
328 ~~inpatient per diem rate shall be adjusted to cost, effective~~
329 ~~July 1, 2002.~~
330
331 ~~No later than October 1 of each year, the agency must provide~~
332 ~~estimated costs for any adjustment in a hospital inpatient per~~
333 ~~diem pursuant to this paragraph to the Executive Office of the~~

334 ~~Governor, the House of Representatives General Appropriations~~
335 ~~Committee, and the Senate Appropriations Committee. Before the~~
336 ~~agency implements a change in a hospital's inpatient per diem~~
337 ~~rate pursuant to this paragraph, the Legislature must have~~
338 ~~specifically appropriated sufficient funds in the General~~
339 ~~Appropriations Act to support the increase in cost as estimated~~
340 ~~by the agency.~~
341 Section 5. Subsections (7), (14), and (19) of section
342 409.906, Florida Statutes, are amended, and subsection (26) is
343 added to that section, to read:
344 409.906 Optional Medicaid services.--Subject to specific
345 appropriations, the agency may make payments for services which
346 are optional to the state under Title XIX of the Social Security
347 Act and are furnished by Medicaid providers to recipients who
348 are determined to be eligible on the dates on which the services
349 were provided. Any optional service that is provided shall be
350 provided only when medically necessary and in accordance with
351 state and federal law. Optional services rendered by providers
352 in mobile units to Medicaid recipients may be restricted or
353 prohibited by the agency. Nothing in this section shall be
354 construed to prevent or limit the agency from adjusting fees,
355 reimbursement rates, lengths of stay, number of visits, or
356 number of services, or making any other adjustments necessary to
357 comply with the availability of moneys and any limitations or
358 directions provided for in the General Appropriations Act or
359 chapter 216. If necessary to safeguard the state's systems of
360 providing services to elderly and disabled persons and subject
361 to the notice and review provisions of s. 216.177, the Governor

362 may direct the Agency for Health Care Administration to amend
363 the Medicaid state plan to delete the optional Medicaid service
364 known as "Intermediate Care Facilities for the Developmentally
365 Disabled." Optional services may include:
366 (7) CHIROPRACTIC SERVICES.--<u>For 2 fiscal years beginning</u>
367 <u>July 1, 2008, and ending June 30, 2010, the agency may not pay</u>
368 <u>for chiropractic services.</u> ~~The agency may pay for manual~~
369 ~~manipulation of the spine and initial services, screening, and X~~
370 ~~rays provided to a recipient by a licensed chiropractic~~
371 ~~physician.~~
372 (14) HOSPICE CARE SERVICES.--<u>For 2 fiscal years beginning</u>
373 <u>July 1, 2008, and ending June 30, 2010, the agency may not pay</u>
374 <u>for hospice care services.</u> ~~The agency may pay for all reasonable~~
375 ~~and necessary services for the palliation or management of a~~
376 ~~recipient's terminal illness, if the services are provided by a~~
377 ~~hospice that is licensed under part IV of chapter 400 and meets~~
378 ~~Medicare certification requirements.~~
379 (19) PODIATRIC SERVICES.--<u>For 2 fiscal years beginning</u>
380 <u>July 1, 2008, and ending June 30, 2010, the agency may not pay</u>
381 <u>for podiatric services.</u> ~~The agency may pay for services,~~
382 ~~including diagnosis and medical, surgical, palliative, and~~
383 ~~mechanical treatment, related to ailments of the human foot and~~
384 ~~lower leg, if provided to a recipient by a podiatric physician~~
385 ~~licensed under state law.~~
386 <u>(26) ANESTHESIOLOGIST ASSISTANT SERVICES.--The agency may</u>
387 <u>pay for all services provided to a recipient by an</u>
388 <u>anesthesiologist assistant licensed under s. 458.3475 or s.</u>
389 <u>459.023. Reimbursement for such services must be not less than</u>

390 80 percent of the reimbursement that would be paid to a
391 physician who provided the same services.
392 Section 6. Subsections (13) and (14) of section 409.908,
393 Florida Statutes, as amended by chapter 2007-331, Laws of
394 Florida, are amended, and subsection (23) is added to that
395 section, to read:
396 409.908 Reimbursement of Medicaid providers.--Subject to
397 specific appropriations, the agency shall reimburse Medicaid
398 providers, in accordance with state and federal law, according
399 to methodologies set forth in the rules of the agency and in
400 policy manuals and handbooks incorporated by reference therein.
401 These methodologies may include fee schedules, reimbursement
402 methods based on cost reporting, negotiated fees, competitive
403 bidding pursuant to s. 287.057, and other mechanisms the agency
404 considers efficient and effective for purchasing services or
405 goods on behalf of recipients. If a provider is reimbursed based
406 on cost reporting and submits a cost report late and that cost
407 report would have been used to set a lower reimbursement rate
408 for a rate semester, then the provider's rate for that semester
409 shall be retroactively calculated using the new cost report, and
410 full payment at the recalculated rate shall be effected
411 retroactively. Medicare-granted extensions for filing cost
412 reports, if applicable, shall also apply to Medicaid cost
413 reports. Payment for Medicaid compensable services made on
414 behalf of Medicaid eligible persons is subject to the
415 availability of moneys and any limitations or directions
416 provided for in the General Appropriations Act or chapter 216.
417 Further, nothing in this section shall be construed to prevent

418 or limit the agency from adjusting fees, reimbursement rates,
419 lengths of stay, number of visits, or number of services, or
420 making any other adjustments necessary to comply with the
421 availability of moneys and any limitations or directions
422 provided for in the General Appropriations Act, provided the
423 adjustment is consistent with legislative intent.
424 (13) Medicare premiums for persons eligible for both
425 Medicare and Medicaid coverage shall be paid at the rates
426 established by Title XVIII of the Social Security Act. For
427 Medicare services rendered to Medicaid-eligible persons,
428 Medicaid shall pay Medicare deductibles and coinsurance as
429 follows:
430 ~~(a) Medicaid shall make no payment toward deductibles and~~
431 ~~coinsurance for any service that is not covered by Medicaid.~~
432 (a) ~~(b)~~ Medicaid's financial obligation for deductibles and
433 coinsurance payments shall be based on Medicare allowable fees,
434 not on a provider's billed charges.
435 (b) ~~(c)~~ Medicaid will pay no portion of Medicare
436 deductibles and coinsurance when payment that Medicare has made
437 for the service equals or exceeds what Medicaid would have paid
438 if it had been the sole payor. The combined payment of Medicare
439 and Medicaid shall not exceed the amount Medicaid would have
440 paid had it been the sole payor. The Legislature finds that
441 there has been confusion regarding the reimbursement for
442 services rendered to dually eligible Medicare beneficiaries.
443 Accordingly, the Legislature clarifies that it has always been
444 the intent of the Legislature before and after 1991 that, in
445 reimbursing in accordance with fees established by Title XVIII

446 for premiums, deductibles, and coinsurance for Medicare services
447 rendered by physicians to Medicaid eligible persons, physicians
448 be reimbursed at the lesser of the amount billed by the
449 physician or the Medicaid maximum allowable fee established by
450 the Agency for Health Care Administration, as is permitted by
451 federal law. It has never been the intent of the Legislature
452 with regard to such services rendered by physicians that
453 Medicaid be required to provide any payment for deductibles,
454 coinsurance, or copayments for Medicare cost sharing, or any
455 expenses incurred relating thereto, in excess of the payment
456 amount provided for under the State Medicaid plan for such
457 service. This payment methodology is applicable even in those
458 situations in which the payment for Medicare cost sharing for a
459 qualified Medicare beneficiary with respect to an item or
460 service is reduced or eliminated. This expression of the
461 Legislature is in clarification of existing law and shall apply
462 to payment for, and with respect to provider agreements with
463 respect to, items or services furnished on or after the
464 effective date of this act. This paragraph applies to payment by
465 Medicaid for items and services furnished before the effective
466 date of this act if such payment is the subject of a lawsuit
467 that is based on the provisions of this section, and that is
468 pending as of, or is initiated after, the effective date of this
469 act.
470 (c) ~~(d)~~ Notwithstanding paragraphs (a) and (b) ~~(a)-(c)~~:
471 1. Medicaid payments for Nursing Home Medicare part A
472 coinsurance shall be limited to the Medicaid nursing home per
473 diem rate less any amounts paid by Medicare, but only up to the

474 amount of Medicare coinsurance. The Medicaid per diem rate shall
475 be the rate in effect for the dates of service of the crossover
476 claims and may not be subsequently adjusted due to subsequent
477 per diem rate adjustments.
478 2. Medicaid shall pay all deductibles and coinsurance for
479 Medicare-eligible recipients receiving freestanding end stage
480 renal dialysis center services.
481 3. Medicaid payments for general hospital inpatient
482 services shall be limited to the Medicare deductible and
483 coinsurance per spell of illness. Medicaid payments for hospital
484 Medicare Part A coinsurance shall be limited to the Medicaid
485 hospital per diem rate less any amounts paid by Medicare, but
486 only up to the amount of Medicare coinsurance. Medicaid payments
487 for coinsurance shall be limited to the Medicaid per diem rate
488 in effect for the dates of service of the crossover claims and
489 may not be subsequently adjusted due to subsequent per diem
490 adjustments. ~~Medicaid shall make no payment toward coinsurance~~
491 ~~for Medicare general hospital inpatient services.~~
492 4. Medicaid shall pay all deductibles and coinsurance for
493 Medicare emergency transportation services provided by
494 ambulances licensed pursuant to chapter 401.
495 (14) A provider of prescribed drugs shall be reimbursed
496 the least of the amount billed by the provider, the provider's
497 usual and customary charge, or the Medicaid maximum allowable
498 fee established by the agency, plus a dispensing fee. The
499 Medicaid maximum allowable fee for ingredient cost will be based
500 on the lower of: average wholesale price (AWP) minus 16.4 ~~15.4~~
501 percent, wholesaler acquisition cost (WAC) plus 4.75 ~~5.75~~

502 percent, the federal upper limit (FUL), the state maximum
503 allowable cost (SMAC), or the usual and customary (UAC) charge
504 billed by the provider. Medicaid providers are required to
505 dispense generic drugs if available at lower cost and the agency
506 has not determined that the branded product is more cost-
507 effective, unless the prescriber has requested and received
508 approval to require the branded product. The agency is directed
509 to implement a variable dispensing fee for payments for
510 prescribed medicines while ensuring continued access for
511 Medicaid recipients. The variable dispensing fee may be based
512 upon, but not limited to, either or both the volume of
513 prescriptions dispensed by a specific pharmacy provider, the
514 volume of prescriptions dispensed to an individual recipient,
515 and dispensing of preferred-drug-list products. The agency may
516 increase the pharmacy dispensing fee authorized by statute and
517 in the annual General Appropriations Act by $0.50 for the
518 dispensing of a Medicaid preferred-drug-list product and reduce
519 the pharmacy dispensing fee by $0.50 for the dispensing of a
520 Medicaid product that is not included on the preferred drug
521 list. The agency may establish a supplemental pharmaceutical
522 dispensing fee to be paid to providers returning unused unit-
523 dose packaged medications to stock and crediting the Medicaid
524 program for the ingredient cost of those medications if the
525 ingredient costs to be credited exceed the value of the
526 supplemental dispensing fee. The agency is authorized to limit
527 reimbursement for prescribed medicine in order to comply with
528 any limitations or directions provided for in the General

529 Appropriations Act, which may include implementing a prospective
530 or concurrent utilization review program.
531 (23)(a) The agency shall establish rates at a level that
532 ensures no increase in statewide expenditures resulting from a
533 change in unit costs for 2 fiscal years effective July 1, 2008.
534 Reimbursement rates for the 2 fiscal years shall be as provided
535 in the General Appropriations Act.
536 (b) This subsection applies to the following provider
537 types:
538 1. Inpatient hospitals.
539 2. Outpatient hospitals.
540 3. Nursing homes.
541 4. County health departments.
542 5. Community intermediate care facilities for the
543 developmentally disabled.
544
545 The agency shall apply the effect of this subsection to the
546 reimbursement rates for managed care plans and nursing home
547 diversion programs.
548 (c) The agency shall create a workgroup on hospital
549 reimbursement, a workgroup on nursing facility reimbursement,
550 and a workgroup on managed care plan payment. The workgroups
551 shall evaluate alternative reimbursement and payment
552 methodologies for hospitals, nursing facilities, and managed
553 care plans, including prospective payment methodologies for
554 hospitals and nursing facilities. The nursing facility workgroup
555 shall also consider price-based methodologies for indirect care
556 and acuity adjustments for direct care. The agency shall submit

557 a report on the evaluated alternative reimbursement
558 methodologies to the relevant committees of the Senate and the
559 House of Representatives by November 1, 2009.
560 (d) This subsection expires June 30, 2010.
561 Section 7. Paragraph (a) of subsection (2) of section
562 409.911, Florida Statutes, is amended to read:
563 409.911 Disproportionate share program.--Subject to
564 specific allocations established within the General
565 Appropriations Act and any limitations established pursuant to
566 chapter 216, the agency shall distribute, pursuant to this
567 section, moneys to hospitals providing a disproportionate share
568 of Medicaid or charity care services by making quarterly
569 Medicaid payments as required. Notwithstanding the provisions of
570 s. 409.915, counties are exempt from contributing toward the
571 cost of this special reimbursement for hospitals serving a
572 disproportionate share of low-income patients.
573 (2) The Agency for Health Care Administration shall use
574 the following actual audited data to determine the Medicaid days
575 and charity care to be used in calculating the disproportionate
576 share payment:
577 (a) The average of the 2002, 2003, and 2004 ~~2000, 2001,~~
578 ~~and 2002~~ audited disproportionate share data to determine each
579 hospital's Medicaid days and charity care for the 2008-2009
580 ~~2006-2007~~ state fiscal year.
581 Section 8. Section 409.9112, Florida Statutes, is amended
582 to read:
583 409.9112 Disproportionate share program for regional
584 perinatal intensive care centers.--In addition to the payments

585 made under s. 409.911, the Agency for Health Care Administration
586 shall design and implement a system of making disproportionate
587 share payments to those hospitals that participate in the
588 regional perinatal intensive care center program established
589 pursuant to chapter 383. This system of payments shall conform
590 with federal requirements and shall distribute funds in each
591 fiscal year for which an appropriation is made by making
592 quarterly Medicaid payments. Notwithstanding the provisions of
593 s. 409.915, counties are exempt from contributing toward the
594 cost of this special reimbursement for hospitals serving a
595 disproportionate share of low-income patients. For the state
596 fiscal year 2008-2009 ~~2005-2006~~, the agency shall not distribute
597 moneys under the regional perinatal intensive care centers
598 disproportionate share program.
599 (1) The following formula shall be used by the agency to
600 calculate the total amount earned for hospitals that participate
601 in the regional perinatal intensive care center program:
602
603 TAE = HDSP/THDSP
604
605 Where:
606 TAE = total amount earned by a regional perinatal intensive
607 care center.
608 HDSP = the prior state fiscal year regional perinatal
609 intensive care center disproportionate share payment to the
610 individual hospital.

611 THDSP = the prior state fiscal year total regional
612 perinatal intensive care center disproportionate share payments
613 to all hospitals.
614 (2) The total additional payment for hospitals that
615 participate in the regional perinatal intensive care center
616 program shall be calculated by the agency as follows:
617
618 TAP = TAE x TA
619
620 Where:
621 TAP = total additional payment for a regional perinatal
622 intensive care center.
623 TAE = total amount earned by a regional perinatal intensive
624 care center.
625 TA = total appropriation for the regional perinatal
626 intensive care center disproportionate share program.
627 (3) In order to receive payments under this section, a
628 hospital must be participating in the regional perinatal
629 intensive care center program pursuant to chapter 383 and must
630 meet the following additional requirements:
631 (a) Agree to conform to all departmental and agency
632 requirements to ensure high quality in the provision of
633 services, including criteria adopted by departmental and agency
634 rule concerning staffing ratios, medical records, standards of
635 care, equipment, space, and such other standards and criteria as
636 the department and agency deem appropriate as specified by rule.
637 (b) Agree to provide information to the department and
638 agency, in a form and manner to be prescribed by rule of the

639 department and agency, concerning the care provided to all
640 patients in neonatal intensive care centers and high-risk
641 maternity care.
642 (c) Agree to accept all patients for neonatal intensive
643 care and high-risk maternity care, regardless of ability to pay,
644 on a functional space-available basis.
645 (d) Agree to develop arrangements with other maternity and
646 neonatal care providers in the hospital's region for the
647 appropriate receipt and transfer of patients in need of
648 specialized maternity and neonatal intensive care services.
649 (e) Agree to establish and provide a developmental
650 evaluation and services program for certain high-risk neonates,
651 as prescribed and defined by rule of the department.
652 (f) Agree to sponsor a program of continuing education in
653 perinatal care for health care professionals within the region
654 of the hospital, as specified by rule.
655 (g) Agree to provide backup and referral services to the
656 department's county health departments and other low-income
657 perinatal providers within the hospital's region, including the
658 development of written agreements between these organizations
659 and the hospital.
660 (h) Agree to arrange for transportation for high-risk
661 obstetrical patients and neonates in need of transfer from the
662 community to the hospital or from the hospital to another more
663 appropriate facility.
664 (4) Hospitals which fail to comply with any of the
665 conditions in subsection (3) or the applicable rules of the
666 department and agency shall not receive any payments under this

667 section until full compliance is achieved. A hospital which is
668 not in compliance in two or more consecutive quarters shall not
669 receive its share of the funds. Any forfeited funds shall be
670 distributed by the remaining participating regional perinatal
671 intensive care center program hospitals.
672 Section 9. Section 409.9113, Florida Statutes, is amended
673 to read:
674 409.9113 Disproportionate share program for teaching
675 hospitals.--In addition to the payments made under ss. 409.911
676 and 409.9112, the Agency for Health Care Administration shall
677 make disproportionate share payments to statutorily defined
678 teaching hospitals for their increased costs associated with
679 medical education programs and for tertiary health care services
680 provided to the indigent. This system of payments shall conform
681 with federal requirements and shall distribute funds in each
682 fiscal year for which an appropriation is made by making
683 quarterly Medicaid payments. Notwithstanding s. 409.915,
684 counties are exempt from contributing toward the cost of this
685 special reimbursement for hospitals serving a disproportionate
686 share of low-income patients. For the state fiscal year 2008-
687 2009 ~~2006-2007~~, the agency shall distribute the moneys provided
688 in the General Appropriations Act to statutorily defined
689 teaching hospitals and family practice teaching hospitals under
690 the teaching hospital disproportionate share program. The funds
691 provided for statutorily defined teaching hospitals shall be
692 distributed in the same proportion as the state fiscal year
693 2003-2004 teaching hospital disproportionate share funds were
694 distributed or as otherwise provided in the General

695 Appropriations Act. The funds provided for family practice
696 teaching hospitals shall be distributed equally among family
697 practice teaching hospitals.
698 (1) On or before September 15 of each year, the Agency for
699 Health Care Administration shall calculate an allocation
700 fraction to be used for distributing funds to state statutory
701 teaching hospitals. Subsequent to the end of each quarter of the
702 state fiscal year, the agency shall distribute to each statutory
703 teaching hospital, as defined in s. 408.07, an amount determined
704 by multiplying one-fourth of the funds appropriated for this
705 purpose by the Legislature times such hospital's allocation
706 fraction. The allocation fraction for each such hospital shall
707 be determined by the sum of three primary factors, divided by
708 three. The primary factors are:
709 (a) The number of nationally accredited graduate medical
710 education programs offered by the hospital, including programs
711 accredited by the Accreditation Council for Graduate Medical
712 Education and the combined Internal Medicine and Pediatrics
713 programs acceptable to both the American Board of Internal
714 Medicine and the American Board of Pediatrics at the beginning
715 of the state fiscal year preceding the date on which the
716 allocation fraction is calculated. The numerical value of this
717 factor is the fraction that the hospital represents of the total
718 number of programs, where the total is computed for all state
719 statutory teaching hospitals.
720 (b) The number of full-time equivalent trainees in the
721 hospital, which comprises two components:

722 1. The number of trainees enrolled in nationally
723 accredited graduate medical education programs, as defined in
724 paragraph (a). Full-time equivalents are computed using the
725 fraction of the year during which each trainee is primarily
726 assigned to the given institution, over the state fiscal year
727 preceding the date on which the allocation fraction is
728 calculated. The numerical value of this factor is the fraction
729 that the hospital represents of the total number of full-time
730 equivalent trainees enrolled in accredited graduate programs,
731 where the total is computed for all state statutory teaching
732 hospitals.
733 2. The number of medical students enrolled in accredited
734 colleges of medicine and engaged in clinical activities,
735 including required clinical clerkships and clinical electives.
736 Full-time equivalents are computed using the fraction of the
737 year during which each trainee is primarily assigned to the
738 given institution, over the course of the state fiscal year
739 preceding the date on which the allocation fraction is
740 calculated. The numerical value of this factor is the fraction
741 that the given hospital represents of the total number of full-
742 time equivalent students enrolled in accredited colleges of
743 medicine, where the total is computed for all state statutory
744 teaching hospitals.
745
746 The primary factor for full-time equivalent trainees is computed
747 as the sum of these two components, divided by two.
748 (c) A service index that comprises three components:

749 1. The Agency for Health Care Administration Service
750 Index, computed by applying the standard Service Inventory
751 Scores established by the Agency for Health Care Administration
752 to services offered by the given hospital, as reported on
753 Worksheet A-2 for the last fiscal year reported to the agency
754 before the date on which the allocation fraction is calculated.
755 The numerical value of this factor is the fraction that the
756 given hospital represents of the total Agency for Health Care
757 Administration Service Index values, where the total is computed
758 for all state statutory teaching hospitals.
759 2. A volume-weighted service index, computed by applying
760 the standard Service Inventory Scores established by the Agency
761 for Health Care Administration to the volume of each service,
762 expressed in terms of the standard units of measure reported on
763 Worksheet A-2 for the last fiscal year reported to the agency
764 before the date on which the allocation factor is calculated.
765 The numerical value of this factor is the fraction that the
766 given hospital represents of the total volume-weighted service
767 index values, where the total is computed for all state
768 statutory teaching hospitals.
769 3. Total Medicaid payments to each hospital for direct
770 inpatient and outpatient services during the fiscal year
771 preceding the date on which the allocation factor is calculated.
772 This includes payments made to each hospital for such services
773 by Medicaid prepaid health plans, whether the plan was
774 administered by the hospital or not. The numerical value of this
775 factor is the fraction that each hospital represents of the

776 total of such Medicaid payments, where the total is computed for
777 all state statutory teaching hospitals.
778
779 The primary factor for the service index is computed as the sum
780 of these three components, divided by three.
781 (2) By October 1 of each year, the agency shall use the
782 following formula to calculate the maximum additional
783 disproportionate share payment for statutorily defined teaching
784 hospitals:
785
786 TAP = THAF x A
787
788 Where:
789 TAP = total additional payment.
790 THAF = teaching hospital allocation factor.
791 A = amount appropriated for a teaching hospital
792 disproportionate share program.
793 Section 10. Section 409.9117, Florida Statutes, is amended
794 to read:
795 409.9117 Primary care disproportionate share program.--For
796 the state fiscal year 2008-2009 ~~2006-2007~~, the agency shall not
797 distribute moneys under the primary care disproportionate share
798 program.
799 (1) If federal funds are available for disproportionate
800 share programs in addition to those otherwise provided by law,
801 there shall be created a primary care disproportionate share
802 program.

803 (2) The following formula shall be used by the agency to
804 calculate the total amount earned for hospitals that participate
805 in the primary care disproportionate share program:
806
807 TAE = HDSP/THDSP
808
809 Where:
810 TAE = total amount earned by a hospital participating in
811 the primary care disproportionate share program.
812 HDSP = the prior state fiscal year primary care
813 disproportionate share payment to the individual hospital.
814 THDSP = the prior state fiscal year total primary care
815 disproportionate share payments to all hospitals.
816 (3) The total additional payment for hospitals that
817 participate in the primary care disproportionate share program
818 shall be calculated by the agency as follows:
819
820 TAP = TAE x TA
821
822 Where:
823 TAP = total additional payment for a primary care hospital.
824 TAE = total amount earned by a primary care hospital.
825 TA = total appropriation for the primary care
826 disproportionate share program.
827 (4) In the establishment and funding of this program, the
828 agency shall use the following criteria in addition to those
829 specified in s. 409.911, payments may not be made to a hospital
830 unless the hospital agrees to:

831 (a) Cooperate with a Medicaid prepaid health plan, if one
832 exists in the community.
833 (b) Ensure the availability of primary and specialty care
834 physicians to Medicaid recipients who are not enrolled in a
835 prepaid capitated arrangement and who are in need of access to
836 such physicians.
837 (c) Coordinate and provide primary care services free of
838 charge, except copayments, to all persons with incomes up to 100
839 percent of the federal poverty level who are not otherwise
840 covered by Medicaid or another program administered by a
841 governmental entity, and to provide such services based on a
842 sliding fee scale to all persons with incomes up to 200 percent
843 of the federal poverty level who are not otherwise covered by
844 Medicaid or another program administered by a governmental
845 entity, except that eligibility may be limited to persons who
846 reside within a more limited area, as agreed to by the agency
847 and the hospital.
848 (d) Contract with any federally qualified health center,
849 if one exists within the agreed geopolitical boundaries,
850 concerning the provision of primary care services, in order to
851 guarantee delivery of services in a nonduplicative fashion, and
852 to provide for referral arrangements, privileges, and
853 admissions, as appropriate. The hospital shall agree to provide
854 at an onsite or offsite facility primary care services within 24
855 hours to which all Medicaid recipients and persons eligible
856 under this paragraph who do not require emergency room services
857 are referred during normal daylight hours.

858 (e) Cooperate with the agency, the county, and other
859 entities to ensure the provision of certain public health
860 services, case management, referral and acceptance of patients,
861 and sharing of epidemiological data, as the agency and the
862 hospital find mutually necessary and desirable to promote and
863 protect the public health within the agreed geopolitical
864 boundaries.
865 (f) In cooperation with the county in which the hospital
866 resides, develop a low-cost, outpatient, prepaid health care
867 program to persons who are not eligible for the Medicaid
868 program, and who reside within the area.
869 (g) Provide inpatient services to residents within the
870 area who are not eligible for Medicaid or Medicare, and who do
871 not have private health insurance, regardless of ability to pay,
872 on the basis of available space, except that nothing shall
873 prevent the hospital from establishing bill collection programs
874 based on ability to pay.
875 (h) Work with the Florida Healthy Kids Corporation, the
876 Florida Health Care Purchasing Cooperative, and business health
877 coalitions, as appropriate, to develop a feasibility study and
878 plan to provide a low-cost comprehensive health insurance plan
879 to persons who reside within the area and who do not have access
880 to such a plan.
881 (i) Work with public health officials and other experts to
882 provide community health education and prevention activities
883 designed to promote healthy lifestyles and appropriate use of
884 health services.

885 (j) Work with the local health council to develop a plan
886 for promoting access to affordable health care services for all
887 persons who reside within the area, including, but not limited
888 to, public health services, primary care services, inpatient
889 services, and affordable health insurance generally.
890
891 Any hospital that fails to comply with any of the provisions of
892 this subsection, or any other contractual condition, may not
893 receive payments under this section until full compliance is
894 achieved.
895 Section 11. Paragraph (a) of subsection (39) of section
896 409.912, Florida Statutes, is amended, and subsection (53) is
897 added to that section, to read:
898 409.912 Cost-effective purchasing of health care.--The
899 agency shall purchase goods and services for Medicaid recipients
900 in the most cost-effective manner consistent with the delivery
901 of quality medical care. To ensure that medical services are
902 effectively utilized, the agency may, in any case, require a
903 confirmation or second physician's opinion of the correct
904 diagnosis for purposes of authorizing future services under the
905 Medicaid program. This section does not restrict access to
906 emergency services or poststabilization care services as defined
907 in 42 C.F.R. part 438.114. Such confirmation or second opinion
908 shall be rendered in a manner approved by the agency. The agency
909 shall maximize the use of prepaid per capita and prepaid
910 aggregate fixed-sum basis services when appropriate and other
911 alternative service delivery and reimbursement methodologies,
912 including competitive bidding pursuant to s. 287.057, designed

913 to facilitate the cost-effective purchase of a case-managed
914 continuum of care. The agency shall also require providers to
915 minimize the exposure of recipients to the need for acute
916 inpatient, custodial, and other institutional care and the
917 inappropriate or unnecessary use of high-cost services. The
918 agency shall contract with a vendor to monitor and evaluate the
919 clinical practice patterns of providers in order to identify
920 trends that are outside the normal practice patterns of a
921 provider's professional peers or the national guidelines of a
922 provider's professional association. The vendor must be able to
923 provide information and counseling to a provider whose practice
924 patterns are outside the norms, in consultation with the agency,
925 to improve patient care and reduce inappropriate utilization.
926 The agency may mandate prior authorization, drug therapy
927 management, or disease management participation for certain
928 populations of Medicaid beneficiaries, certain drug classes, or
929 particular drugs to prevent fraud, abuse, overuse, and possible
930 dangerous drug interactions. The Pharmaceutical and Therapeutics
931 Committee shall make recommendations to the agency on drugs for
932 which prior authorization is required. The agency shall inform
933 the Pharmaceutical and Therapeutics Committee of its decisions
934 regarding drugs subject to prior authorization. The agency is
935 authorized to limit the entities it contracts with or enrolls as
936 Medicaid providers by developing a provider network through
937 provider credentialing. The agency may competitively bid single-
938 source-provider contracts if procurement of goods or services
939 results in demonstrated cost savings to the state without
940 limiting access to care. The agency may limit its network based

941 on the assessment of beneficiary access to care, provider
942 availability, provider quality standards, time and distance
943 standards for access to care, the cultural competence of the
944 provider network, demographic characteristics of Medicaid
945 beneficiaries, practice and provider-to-beneficiary standards,
946 appointment wait times, beneficiary use of services, provider
947 turnover, provider profiling, provider licensure history,
948 previous program integrity investigations and findings, peer
949 review, provider Medicaid policy and billing compliance records,
950 clinical and medical record audits, and other factors. Providers
951 shall not be entitled to enrollment in the Medicaid provider
952 network. The agency shall determine instances in which allowing
953 Medicaid beneficiaries to purchase durable medical equipment and
954 other goods is less expensive to the Medicaid program than long-
955 term rental of the equipment or goods. The agency may establish
956 rules to facilitate purchases in lieu of long-term rentals in
957 order to protect against fraud and abuse in the Medicaid program
958 as defined in s. 409.913. The agency may seek federal waivers
959 necessary to administer these policies.
960 (39)(a) The agency shall implement a Medicaid prescribed-
961 drug spending-control program that includes the following
962 components:
963 1. A Medicaid preferred drug list, which shall be a
964 listing of cost-effective therapeutic options recommended by the
965 Medicaid Pharmacy and Therapeutics Committee established
966 pursuant to s. 409.91195 and adopted by the agency for each
967 therapeutic class on the preferred drug list. At the discretion
968 of the committee, and when feasible, the preferred drug list

969 should include at least two products in a therapeutic class. The
970 agency may post the preferred drug list and updates to the
971 preferred drug list on an Internet website without following the
972 rulemaking procedures of chapter 120. Antiretroviral agents are
973 excluded from the preferred drug list. The agency shall also
974 limit the amount of a prescribed drug dispensed to no more than
975 a 34-day supply unless the drug products' smallest marketed
976 package is greater than a 34-day supply, or the drug is
977 determined by the agency to be a maintenance drug in which case
978 a 100-day maximum supply may be authorized. The agency is
979 authorized to seek any federal waivers necessary to implement
980 these cost-control programs and to continue participation in the
981 federal Medicaid rebate program, or alternatively to negotiate
982 state-only manufacturer rebates. The agency may adopt rules to
983 implement this subparagraph. The agency shall continue to
984 provide unlimited contraceptive drugs and items. The agency must
985 establish procedures to ensure that:
986 a. There will be a response to a request for prior
987 consultation by telephone or other telecommunication device
988 within 24 hours after receipt of a request for prior
989 consultation; and
990 b. A 72-hour supply of the drug prescribed will be
991 provided in an emergency or when the agency does not provide a
992 response within 24 hours as required by sub-subparagraph a.
993 2. Reimbursement to pharmacies for Medicaid prescribed
994 drugs shall be set at the lesser of: the average wholesale price
995 (AWP) minus 16.4 ~~15.4~~ percent, the wholesaler acquisition cost
996 (WAC) plus 4.75 ~~5.75~~ percent, the federal upper limit (FUL), the

997 state maximum allowable cost (SMAC), or the usual and customary
998 (UAC) charge billed by the provider.
999 3. The agency shall develop and implement a process for
1000 managing the drug therapies of Medicaid recipients who are using
1001 significant numbers of prescribed drugs each month. The
1002 management process may include, but is not limited to,
1003 comprehensive, physician-directed medical-record reviews, claims
1004 analyses, and case evaluations to determine the medical
1005 necessity and appropriateness of a patient's treatment plan and
1006 drug therapies. The agency may contract with a private
1007 organization to provide drug-program-management services. The
1008 Medicaid drug benefit management program shall include
1009 initiatives to manage drug therapies for HIV/AIDS patients,
1010 patients using 20 or more unique prescriptions in a 180-day
1011 period, and the top 1,000 patients in annual spending. The
1012 agency shall enroll any Medicaid recipient in the drug benefit
1013 management program if he or she meets the specifications of this
1014 provision and is not enrolled in a Medicaid health maintenance
1015 organization.
1016 4. The agency may limit the size of its pharmacy network
1017 based on need, competitive bidding, price negotiations,
1018 credentialing, or similar criteria. The agency shall give
1019 special consideration to rural areas in determining the size and
1020 location of pharmacies included in the Medicaid pharmacy
1021 network. A pharmacy credentialing process may include criteria
1022 such as a pharmacy's full-service status, location, size,
1023 patient educational programs, patient consultation, disease
1024 management services, and other characteristics. The agency may

1025 impose a moratorium on Medicaid pharmacy enrollment when it is
1026 determined that it has a sufficient number of Medicaid-
1027 participating providers. The agency must allow dispensing
1028 practitioners to participate as a part of the Medicaid pharmacy
1029 network regardless of the practitioner's proximity to any other
1030 entity that is dispensing prescription drugs under the Medicaid
1031 program. A dispensing practitioner must meet all credentialing
1032 requirements applicable to his or her practice, as determined by
1033 the agency.
1034 5. The agency shall develop and implement a program that
1035 requires Medicaid practitioners who prescribe drugs to use a
1036 counterfeit-proof prescription pad for Medicaid prescriptions.
1037 The agency shall require the use of standardized counterfeit-
1038 proof prescription pads by Medicaid-participating prescribers or
1039 prescribers who write prescriptions for Medicaid recipients. The
1040 agency may implement the program in targeted geographic areas or
1041 statewide.
1042 6. The agency may enter into arrangements that require
1043 manufacturers of generic drugs prescribed to Medicaid recipients
1044 to provide rebates of at least 15.1 percent of the average
1045 manufacturer price for the manufacturer's generic products.
1046 These arrangements shall require that if a generic-drug
1047 manufacturer pays federal rebates for Medicaid-reimbursed drugs
1048 at a level below 15.1 percent, the manufacturer must provide a
1049 supplemental rebate to the state in an amount necessary to
1050 achieve a 15.1-percent rebate level.
1051 7. The agency may establish a preferred drug list as
1052 described in this subsection, and, pursuant to the establishment

1053 of such preferred drug list, it is authorized to negotiate
1054 supplemental rebates from manufacturers that are in addition to
1055 those required by Title XIX of the Social Security Act and at no
1056 less than 14 percent of the average manufacturer price as
1057 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
1058 the federal or supplemental rebate, or both, equals or exceeds
1059 29 percent. There is no upper limit on the supplemental rebates
1060 the agency may negotiate. The agency may determine that specific
1061 products, brand-name or generic, are competitive at lower rebate
1062 percentages. Agreement to pay the minimum supplemental rebate
1063 percentage will guarantee a manufacturer that the Medicaid
1064 Pharmaceutical and Therapeutics Committee will consider a
1065 product for inclusion on the preferred drug list. However, a
1066 pharmaceutical manufacturer is not guaranteed placement on the
1067 preferred drug list by simply paying the minimum supplemental
1068 rebate. Agency decisions will be made on the clinical efficacy
1069 of a drug and recommendations of the Medicaid Pharmaceutical and
1070 Therapeutics Committee, as well as the price of competing
1071 products minus federal and state rebates. The agency is
1072 authorized to contract with an outside agency or contractor to
1073 conduct negotiations for supplemental rebates. For the purposes
1074 of this section, the term "supplemental rebates" means cash
1075 rebates. Effective July 1, 2004, value-added programs as a
1076 substitution for supplemental rebates are prohibited. The agency
1077 is authorized to seek any federal waivers to implement this
1078 initiative.
1079 8. The Agency for Health Care Administration shall expand
1080 home delivery of pharmacy products. To assist Medicaid patients

1081 in securing their prescriptions and reduce program costs, the
1082 agency shall expand its current mail-order-pharmacy diabetes-
1083 supply program to include all generic and brand-name drugs used
1084 by Medicaid patients with diabetes. Medicaid recipients in the
1085 current program may obtain nondiabetes drugs on a voluntary
1086 basis. This initiative is limited to the geographic area covered
1087 by the current contract. The agency may seek and implement any
1088 federal waivers necessary to implement this subparagraph.
1089 9. The agency shall limit to one dose per month any drug
1090 prescribed to treat erectile dysfunction.
1091 10.a. The agency may implement a Medicaid behavioral drug
1092 management system. The agency may contract with a vendor that
1093 has experience in operating behavioral drug management systems
1094 to implement this program. The agency is authorized to seek
1095 federal waivers to implement this program.
1096 b. The agency, in conjunction with the Department of
1097 Children and Family Services, may implement the Medicaid
1098 behavioral drug management system that is designed to improve
1099 the quality of care and behavioral health prescribing practices
1100 based on best practice guidelines, improve patient adherence to
1101 medication plans, reduce clinical risk, and lower prescribed
1102 drug costs and the rate of inappropriate spending on Medicaid
1103 behavioral drugs. The program may include the following
1104 elements:
1105 (I) Provide for the development and adoption of best
1106 practice guidelines for behavioral health-related drugs such as
1107 antipsychotics, antidepressants, and medications for treating
1108 bipolar disorders and other behavioral conditions; translate

1109 them into practice; review behavioral health prescribers and
1110 compare their prescribing patterns to a number of indicators
1111 that are based on national standards; and determine deviations
1112 from best practice guidelines.
1113 (II) Implement processes for providing feedback to and
1114 educating prescribers using best practice educational materials
1115 and peer-to-peer consultation.
1116 (III) Assess Medicaid beneficiaries who are outliers in
1117 their use of behavioral health drugs with regard to the numbers
1118 and types of drugs taken, drug dosages, combination drug
1119 therapies, and other indicators of improper use of behavioral
1120 health drugs.
1121 (IV) Alert prescribers to patients who fail to refill
1122 prescriptions in a timely fashion, are prescribed multiple same-
1123 class behavioral health drugs, and may have other potential
1124 medication problems.
1125 (V) Track spending trends for behavioral health drugs and
1126 deviation from best practice guidelines.
1127 (VI) Use educational and technological approaches to
1128 promote best practices, educate consumers, and train prescribers
1129 in the use of practice guidelines.
1130 (VII) Disseminate electronic and published materials.
1131 (VIII) Hold statewide and regional conferences.
1132 (IX) Implement a disease management program with a model
1133 quality-based medication component for severely mentally ill
1134 individuals and emotionally disturbed children who are high
1135 users of care.

1136 11.a. The agency shall implement a Medicaid prescription
1137 drug management system. The agency may contract with a vendor
1138 that has experience in operating prescription drug management
1139 systems in order to implement this system. Any management system
1140 that is implemented in accordance with this subparagraph must
1141 rely on cooperation between physicians and pharmacists to
1142 determine appropriate practice patterns and clinical guidelines
1143 to improve the prescribing, dispensing, and use of drugs in the
1144 Medicaid program. The agency may seek federal waivers to
1145 implement this program.
1146 b. The drug management system must be designed to improve
1147 the quality of care and prescribing practices based on best
1148 practice guidelines, improve patient adherence to medication
1149 plans, reduce clinical risk, and lower prescribed drug costs and
1150 the rate of inappropriate spending on Medicaid prescription
1151 drugs. The program must:
1152 (I) Provide for the development and adoption of best
1153 practice guidelines for the prescribing and use of drugs in the
1154 Medicaid program, including translating best practice guidelines
1155 into practice; reviewing prescriber patterns and comparing them
1156 to indicators that are based on national standards and practice
1157 patterns of clinical peers in their community, statewide, and
1158 nationally; and determine deviations from best practice
1159 guidelines.
1160 (II) Implement processes for providing feedback to and
1161 educating prescribers using best practice educational materials
1162 and peer-to-peer consultation.

1163 (III) Assess Medicaid recipients who are outliers in their
1164 use of a single or multiple prescription drugs with regard to
1165 the numbers and types of drugs taken, drug dosages, combination
1166 drug therapies, and other indicators of improper use of
1167 prescription drugs.
1168 (IV) Alert prescribers to patients who fail to refill
1169 prescriptions in a timely fashion, are prescribed multiple drugs
1170 that may be redundant or contraindicated, or may have other
1171 potential medication problems.
1172 (V) Track spending trends for prescription drugs and
1173 deviation from best practice guidelines.
1174 (VI) Use educational and technological approaches to
1175 promote best practices, educate consumers, and train prescribers
1176 in the use of practice guidelines.
1177 (VII) Disseminate electronic and published materials.
1178 (VIII) Hold statewide and regional conferences.
1179 (IX) Implement disease management programs in cooperation
1180 with physicians and pharmacists, along with a model quality-
1181 based medication component for individuals having chronic
1182 medical conditions.
1183 12. The agency is authorized to contract for drug rebate
1184 administration, including, but not limited to, calculating
1185 rebate amounts, invoicing manufacturers, negotiating disputes
1186 with manufacturers, and maintaining a database of rebate
1187 collections.
1188 13. The agency may specify the preferred daily dosing form
1189 or strength for the purpose of promoting best practices with
1190 regard to the prescribing of certain drugs as specified in the

1191 General Appropriations Act and ensuring cost-effective
1192 prescribing practices.
1193 14. The agency may require prior authorization for
1194 Medicaid-covered prescribed drugs. The agency may, but is not
1195 required to, prior-authorize the use of a product:
1196 a. For an indication not approved in labeling;
1197 b. To comply with certain clinical guidelines; or
1198 c. If the product has the potential for overuse, misuse,
1199 or abuse.
1200
1201 The agency may require the prescribing professional to provide
1202 information about the rationale and supporting medical evidence
1203 for the use of a drug. The agency may post prior authorization
1204 criteria and protocol and updates to the list of drugs that are
1205 subject to prior authorization on an Internet website without
1206 amending its rule or engaging in additional rulemaking.
1207 15. The agency, in conjunction with the Pharmaceutical and
1208 Therapeutics Committee, may require age-related prior
1209 authorizations for certain prescribed drugs. The agency may
1210 preauthorize the use of a drug for a recipient who may not meet
1211 the age requirement or may exceed the length of therapy for use
1212 of this product as recommended by the manufacturer and approved
1213 by the Food and Drug Administration. Prior authorization may
1214 require the prescribing professional to provide information
1215 about the rationale and supporting medical evidence for the use
1216 of a drug.
1217 16. The agency shall implement a step-therapy prior
1218 authorization approval process for medications excluded from the

1219 preferred drug list. Medications listed on the preferred drug
1220 list must be used within the previous 12 months prior to the
1221 alternative medications that are not listed. The step-therapy
1222 prior authorization may require the prescriber to use the
1223 medications of a similar drug class or for a similar medical
1224 indication unless contraindicated in the Food and Drug
1225 Administration labeling. The trial period between the specified
1226 steps may vary according to the medical indication. The step-
1227 therapy approval process shall be developed in accordance with
1228 the committee as stated in s. 409.91195(7) and (8). A drug
1229 product may be approved without meeting the step-therapy prior
1230 authorization criteria if the prescribing physician provides the
1231 agency with additional written medical or clinical documentation
1232 that the product is medically necessary because:
1233 a. There is not a drug on the preferred drug list to treat
1234 the disease or medical condition which is an acceptable clinical
1235 alternative;
1236 b. The alternatives have been ineffective in the treatment
1237 of the beneficiary's disease; or
1238 c. Based on historic evidence and known characteristics of
1239 the patient and the drug, the drug is likely to be ineffective,
1240 or the number of doses have been ineffective.
1241
1242 The agency shall work with the physician to determine the best
1243 alternative for the patient. The agency may adopt rules waiving
1244 the requirements for written clinical documentation for specific
1245 drugs in limited clinical situations.

1246 17. The agency shall implement a return and reuse program
1247 for drugs dispensed by pharmacies to institutional recipients,
1248 which includes payment of a $5 restocking fee for the
1249 implementation and operation of the program. The return and
1250 reuse program shall be implemented electronically and in a
1251 manner that promotes efficiency. The program must permit a
1252 pharmacy to exclude drugs from the program if it is not
1253 practical or cost-effective for the drug to be included and must
1254 provide for the return to inventory of drugs that cannot be
1255 credited or returned in a cost-effective manner. The agency
1256 shall determine if the program has reduced the amount of
1257 Medicaid prescription drugs which are destroyed on an annual
1258 basis and if there are additional ways to ensure more
1259 prescription drugs are not destroyed which could safely be
1260 reused. The agency's conclusion and recommendations shall be
1261 reported to the Legislature by December 1, 2005.
1262 (53) Before seeking an amendment to the state plan for
1263 purposes of implementing programs authorized by the Deficit
1264 Reduction Act of 2005, the agency shall notify the Legislature.
1265 Section 12. Section 409.91211, Florida Statutes, as
1266 amended by chapter 2007-331, Laws of Florida, is amended to
1267 read:
1268 409.91211 Medicaid managed care pilot program.--
1269 (1)(a) The agency is authorized to seek and implement
1270 experimental, pilot, or demonstration project waivers, pursuant
1271 to s. 1115 of the Social Security Act, to create a statewide
1272 initiative to provide for a more efficient and effective service
1273 delivery system that enhances quality of care and client

1274 outcomes in the Florida Medicaid program pursuant to this
1275 section. ~~Phase one of the demonstration shall be implemented in~~
1276 ~~two geographic areas.~~ One demonstration site shall include only
1277 Broward County. A second demonstration site shall initially
1278 include Duval County and shall be expanded to include Baker,
1279 Clay, and Nassau Counties within 1 year after the Duval County
1280 program becomes operational. <u>A third demonstration site shall</u>
1281 <u>include Miami-Dade and Monroe Counties. The agency shall begin</u>
1282 <u>enrolling recipients in the third demonstration site by</u>
1283 <u>September 1, 2009. A fourth demonstration site shall include</u>
1284 <u>Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee, and</u>
1285 <u>Polk Counties. The agency shall begin enrolling recipients in</u>
1286 <u>the fourth demonstration site by September 1, 2010.</u> The agency
1287 shall implement expansion of the program to include the
1288 remaining counties of the state and remaining eligibility groups
1289 in accordance with the process specified in the federally
1290 approved special terms and conditions numbered 11-W-00206/4, as
1291 approved by the federal Centers for Medicare and Medicaid
1292 Services on October 19, 2005, with a goal of full statewide
1293 implementation by June 30, 2011.
1294 (b) This waiver authority is contingent upon federal
1295 approval to preserve the upper-payment-limit funding mechanism
1296 for hospitals, including a guarantee of a reasonable growth
1297 factor, a methodology to allow the use of a portion of these
1298 funds to serve as a risk pool for demonstration sites,
1299 provisions to preserve the state's ability to use
1300 intergovernmental transfers, and provisions to protect the
1301 disproportionate share program authorized pursuant to this

1302 chapter. Upon completion of the evaluation conducted under s. 3,
1303 ch. 2005-133, Laws of Florida, the agency may request statewide
1304 expansion of the demonstration projects. Statewide phase-in to
1305 additional counties shall be contingent upon review and approval
1306 by the Legislature. Under the upper-payment-limit program, or
1307 the low-income pool as implemented by the Agency for Health Care
1308 Administration pursuant to federal waiver, the state matching
1309 funds required for the program shall be provided by local
1310 governmental entities through intergovernmental transfers in
1311 accordance with published federal statutes and regulations. The
1312 Agency for Health Care Administration shall distribute upper-
1313 payment-limit, disproportionate share hospital, and low-income
1314 pool funds according to published federal statutes, regulations,
1315 and waivers and the low-income pool methodology approved by the
1316 federal Centers for Medicare and Medicaid Services.
1317 (c) It is the intent of the Legislature that the low-
1318 income pool plan required by the terms and conditions of the
1319 Medicaid reform waiver and submitted to the federal Centers for
1320 Medicare and Medicaid Services propose the distribution of the
1321 above-mentioned program funds based on the following objectives:
1322 1. Assure a broad and fair distribution of available funds
1323 based on the access provided by Medicaid participating
1324 hospitals, regardless of their ownership status, through their
1325 delivery of inpatient or outpatient care for Medicaid
1326 beneficiaries and uninsured and underinsured individuals;
1327 2. Assure accessible emergency inpatient and outpatient
1328 care for Medicaid beneficiaries and uninsured and underinsured
1329 individuals;

1330 3. Enhance primary, preventive, and other ambulatory care
1331 coverages for uninsured individuals;
1332 4. Promote teaching and specialty hospital programs;
1333 5. Promote the stability and viability of statutorily
1334 defined rural hospitals and hospitals that serve as sole
1335 community hospitals;
1336 6. Recognize the extent of hospital uncompensated care
1337 costs;
1338 7. Maintain and enhance essential community hospital care;
1339 8. Maintain incentives for local governmental entities to
1340 contribute to the cost of uncompensated care;
1341 9. Promote measures to avoid preventable hospitalizations;
1342 10. Account for hospital efficiency; and
1343 11. Contribute to a community's overall health system.
1344 (2) The Legislature intends for the capitated managed care
1345 pilot program to:
1346 (a) Provide recipients in Medicaid fee-for-service or the
1347 MediPass program a comprehensive and coordinated capitated
1348 managed care system for all health care services specified in
1349 ss. 409.905 and 409.906.
1350 (b) Stabilize Medicaid expenditures under the pilot
1351 program compared to Medicaid expenditures in the pilot area for
1352 the 3 years before implementation of the pilot program, while
1353 ensuring:
1354 1. Consumer education and choice.
1355 2. Access to medically necessary services.
1356 3. Coordination of preventative, acute, and long-term
1357 care.

1358 4. Reductions in unnecessary service utilization.
1359 (c) Provide an opportunity to evaluate the feasibility of
1360 statewide implementation of capitated managed care networks as a
1361 replacement for the current Medicaid fee-for-service and
1362 MediPass systems.
1363 (3) The agency shall have the following powers, duties,
1364 and responsibilities with respect to the pilot program:
1365 (a) To implement a system to deliver all mandatory
1366 services specified in s. 409.905 and optional services specified
1367 in s. 409.906, as approved by the Centers for Medicare and
1368 Medicaid Services and the Legislature in the waiver pursuant to
1369 this section. Services to recipients under plan benefits shall
1370 include emergency services provided under s. 409.9128.
1371 (b) To implement a pilot program, including Medicaid
1372 eligibility categories specified in ss. 409.903 and 409.904, as
1373 authorized in an approved federal waiver.
1374 (c) To implement the managed care pilot program that
1375 maximizes all available state and federal funds, including those
1376 obtained through intergovernmental transfers, the low-income
1377 pool, supplemental Medicaid payments, and the disproportionate
1378 share program. Within the parameters allowed by federal statute
1379 and rule, the agency may seek options for making direct payments
1380 to hospitals and physicians employed by or under contract with
1381 the state's medical schools for the costs associated with
1382 graduate medical education under Medicaid reform.
1383 (d) To implement actuarially sound, risk-adjusted
1384 capitation rates for Medicaid recipients in the pilot program

1385 which cover comprehensive care, enhanced services, and
1386 catastrophic care.
1387 (e) To implement policies and guidelines for phasing in
1388 financial risk for approved provider service networks over a 3-
1389 year period. These policies and guidelines must include an
1390 option for a provider service network to be paid fee-for-service
1391 rates. For any provider service network established in a managed
1392 care pilot area, the option to be paid fee-for-service rates
1393 shall include a savings-settlement mechanism that is consistent
1394 with s. 409.912(44). Provider service networks opting to be paid
1395 fee-for-service rates shall have the option to be reimbursed for
1396 prescribed drugs and transportation services on a risk-adjusted
1397 captitated basis. This model shall be converted to a risk-
1398 adjusted capitated rate no later than the beginning of the
1399 fourth year of operation, and may be converted earlier at the
1400 option of the provider service network. Federally qualified
1401 health centers may be offered an opportunity to accept or
1402 decline a contract to participate in any provider network for
1403 prepaid primary care services. The agency shall encourage the
1404 development of innovative methods by provider service networks
1405 to perform administrative functions in a cost-effective manner,
1406 including coordination and consolidation of such functions
1407 between provider service networks and across demonstration
1408 sites.
1409 (f) To implement stop-loss requirements and the transfer
1410 of excess cost to catastrophic coverage that accommodates the
1411 risks associated with the development of the pilot program.

1412 (g) To recommend a process to be used by the Social
1413 Services Estimating Conference to determine and validate the
1414 rate of growth of the per-member costs of providing Medicaid
1415 services under the managed care pilot program.
1416 (h) To implement program standards and credentialing
1417 requirements for capitated managed care networks to participate
1418 in the pilot program, including those related to fiscal
1419 solvency, quality of care, and adequacy of access to health care
1420 providers. The agency shall monitor quarterly and evaluate
1421 annually each plan based on the program standards and
1422 credentialing requirements for adequacy of access to health care
1423 providers to ensure consistent compliance. It is the intent of
1424 the Legislature that, to the extent possible, any pilot program
1425 authorized by the state under this section include any federally
1426 qualified health center, federally qualified rural health
1427 clinic, county health department, the Children's Medical
1428 Services Network within the Department of Health, or other
1429 federally, state, or locally funded entity that serves the
1430 geographic areas within the boundaries of the pilot program that
1431 requests to participate. This paragraph does not relieve an
1432 entity that qualifies as a capitated managed care network under
1433 this section from any other licensure or regulatory requirements
1434 contained in state or federal law which would otherwise apply to
1435 the entity. The standards and credentialing requirements shall
1436 be based upon, but are not limited to:
1437 1. Compliance with the accreditation requirements as
1438 provided in s. 641.512.

1439 2. Compliance with early and periodic screening,
1440 diagnosis, and treatment screening requirements under federal
1441 law.
1442 3. The percentage of voluntary disenrollments.
1443 4. Immunization rates.
1444 5. Standards of the National Committee for Quality
1445 Assurance and other approved accrediting bodies.
1446 6. Recommendations of other authoritative bodies.
1447 7. Specific requirements of the Medicaid program, or
1448 standards designed to specifically meet the unique needs of
1449 Medicaid recipients.
1450 8. Compliance with the health quality improvement system
1451 as established by the agency, which incorporates standards and
1452 guidelines developed by the Centers for Medicare and Medicaid
1453 Services as part of the quality assurance reform initiative.
1454 9. The network's infrastructure capacity to manage
1455 financial transactions, recordkeeping, data collection, and
1456 other administrative functions.
1457 10. The network's ability to submit any financial,
1458 programmatic, or patient-encounter data or other information
1459 required by the agency to determine the actual services provided
1460 and the cost of administering the plan.
1461 (i) To implement a mechanism for providing information to
1462 Medicaid recipients for the purpose of selecting a capitated
1463 managed care plan. For each plan available to a recipient, the
1464 agency, at a minimum, shall ensure that the recipient is
1465 provided with:
1466 1. A list and description of the benefits provided.

1467 2. Information about cost sharing.
1468 3. Plan performance data, if available.
1469 4. An explanation of benefit limitations.
1470 5. Contact information, including identification of
1471 providers participating in the network, geographic locations,
1472 and transportation limitations.
1473 6. Specific information about covered prescription drugs
1474 for each plan.
1475 7.~~6.~~ Any other information the agency determines would
1476 facilitate a recipient's understanding of the plan or insurance
1477 that would best meet his or her needs.
1478 (j) To implement a system to ensure that there is a record
1479 of recipient acknowledgment that choice counseling has been
1480 provided.
1481 (k) To implement a choice counseling system to ensure that
1482 the choice counseling process and related material are designed
1483 to provide counseling through face-to-face interaction, by
1484 telephone, and in writing and through other forms of relevant
1485 media. Materials shall be written at the fourth-grade reading
1486 level and available in a language other than English when 5
1487 percent of the county speaks a language other than English.
1488 Choice counseling shall also use language lines and other
1489 services for impaired recipients, such as TTD/TTY.
1490 (l) To implement a system that prohibits capitated managed
1491 care plans, their representatives, and providers employed by or
1492 contracted with the capitated managed care plans from recruiting
1493 persons eligible for or enrolled in Medicaid, from providing
1494 inducements to Medicaid recipients to select a particular

1495 capitated managed care plan, and from prejudicing Medicaid
1496 recipients against other capitated managed care plans. The
1497 system shall require the entity performing choice counseling to
1498 determine if the recipient has made a choice of a plan or has
1499 opted out because of duress, threats, payment to the recipient,
1500 or incentives promised to the recipient by a third party. If the
1501 choice counseling entity determines that the decision to choose
1502 a plan was unlawfully influenced or a plan violated any of the
1503 provisions of s. 409.912(21), the choice counseling entity shall
1504 immediately report the violation to the agency's program
1505 integrity section for investigation. Verification of choice
1506 counseling by the recipient shall include a stipulation that the
1507 recipient acknowledges the provisions of this subsection.
1508 (m) To implement a choice counseling system that promotes
1509 health literacy and provides information aimed to reduce
1510 minority health disparities through outreach activities for
1511 Medicaid recipients.
1512 (n) To contract with entities to perform choice
1513 counseling. The agency may establish standards and performance
1514 contracts, including standards requiring the contractor to hire
1515 choice counselors who are representative of the state's diverse
1516 population and to train choice counselors in working with
1517 culturally diverse populations.
1518 (o) To implement eligibility assignment processes to
1519 facilitate client choice while ensuring pilot programs of
1520 adequate enrollment levels. These processes shall ensure that
1521 pilot sites have sufficient levels of enrollment to conduct a

1522 valid test of the managed care pilot program within a 2-year
1523 timeframe.
1524 (p) To implement standards for plan compliance, including,
1525 but not limited to, standards for quality assurance and
1526 performance improvement, standards for peer or professional
1527 reviews, grievance policies, and policies for maintaining
1528 program integrity. The agency shall set reasonable standards for
1529 prompt payment of provider claims. The agency shall develop a
1530 data-reporting system, seek input from managed care plans in
1531 order to establish requirements for patient-encounter reporting,
1532 and ensure that the data reported is accurate and complete.
1533 1. In performing the duties required under this section,
1534 the agency shall work with managed care plans to establish a
1535 uniform system to measure and monitor outcomes for a recipient
1536 of Medicaid services.
1537 2. The system shall use financial, clinical, and other
1538 criteria based on pharmacy, medical services, and other data
1539 that is related to the provision of Medicaid services,
1540 including, but not limited to:
1541 a. The Health Plan Employer Data and Information Set
1542 (HEDIS) or measures that are similar to HEDIS.
1543 b. Member satisfaction.
1544 c. Provider satisfaction.
1545 d. Report cards on plan performance and best practices.
1546 e. Compliance with the requirements for prompt payment of
1547 claims under ss. 627.613, 641.3155, and 641.513.

1548 f. Utilization and quality data for the purpose of
1549 ensuring access to medically necessary services, including
1550 underutilization or inappropriate denial of services.
1551 3. The agency shall require the managed care plans that
1552 have contracted with the agency to establish a quality assurance
1553 system that incorporates the provisions of s. 409.912(27) and
1554 any standards, rules, and guidelines developed by the agency.
1555 4. The agency shall establish an encounter database in
1556 order to compile data on health services rendered by health care
1557 practitioners who provide services to patients enrolled in
1558 managed care plans in the demonstration sites. The encounter
1559 database shall:
1560 a. Collect the following for each type of patient
1561 encounter with a health care practitioner or facility,
1562 including:
1563 (I) The demographic characteristics of the patient.
1564 (II) The principal, secondary, and tertiary diagnosis.
1565 (III) The procedure performed.
1566 (IV) The date and location where the procedure was
1567 performed.
1568 (V) The payment for the procedure, if any.
1569 (VI) If applicable, the health care practitioner's
1570 universal identification number.
1571 (VII) If the health care practitioner rendering the
1572 service is a dependent practitioner, the modifiers appropriate
1573 to indicate that the service was delivered by the dependent
1574 practitioner.

1575 b. Collect appropriate information relating to
1576 prescription drugs for each type of patient encounter.
1577 c. Collect appropriate information related to health care
1578 costs and utilization from managed care plans participating in
1579 the demonstration sites.
1580 5. To the extent practicable, when collecting the data the
1581 agency shall use a standardized claim form or electronic
1582 transfer system that is used by health care practitioners,
1583 facilities, and payors.
1584 6. Health care practitioners and facilities in the
1585 demonstration sites shall electronically submit, and managed
1586 care plans participating in the demonstration sites shall
1587 electronically receive, information concerning claims payments
1588 and any other information reasonably related to the encounter
1589 database using a standard format as required by the agency.
1590 7. The agency shall establish reasonable deadlines for
1591 phasing in the electronic transmittal of full encounter data.
1592 8. The system must ensure that the data reported is
1593 accurate and complete.
1594 (q) To implement a grievance resolution process for
1595 Medicaid recipients enrolled in a capitated managed care network
1596 under the pilot program modeled after the subscriber assistance
1597 panel, as created in s. 408.7056. This process shall include a
1598 mechanism for an expedited review of no greater than 24 hours
1599 after notification of a grievance if the life of a Medicaid
1600 recipient is in imminent and emergent jeopardy.
1601 (r) To implement a grievance resolution process for health
1602 care providers employed by or contracted with a capitated

1603 managed care network under the pilot program in order to settle
1604 disputes among the provider and the managed care network or the
1605 provider and the agency.
1606 (s) To implement criteria in an approved federal waiver to
1607 designate health care providers as eligible to participate in
1608 the pilot program. These criteria must include at a minimum
1609 those criteria specified in s. 409.907.
1610 (t) To use health care provider agreements for
1611 participation in the pilot program.
1612 (u) To require that all health care providers under
1613 contract with the pilot program be duly licensed in the state,
1614 if such licensure is available, and meet other criteria as may
1615 be established by the agency. These criteria shall include at a
1616 minimum those criteria specified in s. 409.907.
1617 (v) To ensure that managed care organizations work
1618 collaboratively with other state or local governmental programs
1619 or institutions for the coordination of health care to eligible
1620 individuals receiving services from such programs or
1621 institutions.
1622 (w) To implement procedures to minimize the risk of
1623 Medicaid fraud and abuse in all plans operating in the Medicaid
1624 managed care pilot program authorized in this section.
1625 1. The agency shall ensure that applicable provisions of
1626 this chapter and chapters 414, 626, 641, and 932 which relate to
1627 Medicaid fraud and abuse are applied and enforced at the
1628 demonstration project sites.
1629 2. Providers must have the certification, license, and
1630 credentials that are required by law and waiver requirements.

1631 3. The agency shall ensure that the plan is in compliance
1632 with s. 409.912(21) and (22).
1633 4. The agency shall require that each plan establish
1634 functions and activities governing program integrity in order to
1635 reduce the incidence of fraud and abuse. Plans must report
1636 instances of fraud and abuse pursuant to chapter 641.
1637 5. The plan shall have written administrative and
1638 management arrangements or procedures, including a mandatory
1639 compliance plan, which are designed to guard against fraud and
1640 abuse. The plan shall designate a compliance officer who has
1641 sufficient experience in health care.
1642 6.a. The agency shall require all managed care plan
1643 contractors in the pilot program to report all instances of
1644 suspected fraud and abuse. A failure to report instances of
1645 suspected fraud and abuse is a violation of law and subject to
1646 the penalties provided by law.
1647 b. An instance of fraud and abuse in the managed care
1648 plan, including, but not limited to, defrauding the state health
1649 care benefit program by misrepresentation of fact in reports,
1650 claims, certifications, enrollment claims, demographic
1651 statistics, or patient-encounter data; misrepresentation of the
1652 qualifications of persons rendering health care and ancillary
1653 services; bribery and false statements relating to the delivery
1654 of health care; unfair and deceptive marketing practices; and
1655 false claims actions in the provision of managed care, is a
1656 violation of law and subject to the penalties provided by law.
1657 c. The agency shall require that all contractors make all
1658 files and relevant billing and claims data accessible to state

1659 regulators and investigators and that all such data is linked
1660 into a unified system to ensure consistent reviews and
1661 investigations.
1662 (x) To develop and provide actuarial and benefit design
1663 analyses that indicate the effect on capitation rates and
1664 benefits offered in the pilot program over a prospective 5-year
1665 period based on the following assumptions:
1666 1. Growth in capitation rates which is limited to the
1667 estimated growth rate in general revenue.
1668 2. Growth in capitation rates which is limited to the
1669 average growth rate over the last 3 years in per-recipient
1670 Medicaid expenditures.
1671 3. Growth in capitation rates which is limited to the
1672 growth rate of aggregate Medicaid expenditures between the 2003-
1673 2004 fiscal year and the 2004-2005 fiscal year.
1674 (y) To develop a mechanism to require capitated managed
1675 care plans to reimburse qualified emergency service providers,
1676 including, but not limited to, ambulance services, in accordance
1677 with ss. 409.908 and 409.9128. The pilot program must include a
1678 provision for continuing fee-for-service payments for emergency
1679 services, including, but not limited to, individuals who access
1680 ambulance services or emergency departments and who are
1681 subsequently determined to be eligible for Medicaid services.
1682 (z) To ensure that school districts participating in the
1683 certified school match program pursuant to ss. 409.908(21) and
1684 1011.70 shall be reimbursed by Medicaid, subject to the
1685 limitations of s. 1011.70(1), for a Medicaid-eligible child
1686 participating in the services as authorized in s. 1011.70, as

1687 provided for in s. 409.9071, regardless of whether the child is
1688 enrolled in a capitated managed care network. Capitated managed
1689 care networks must make a good faith effort to execute
1690 agreements with school districts regarding the coordinated
1691 provision of services authorized under s. 1011.70. County health
1692 departments and federally qualified health centers delivering
1693 school-based services pursuant to ss. 381.0056 and 381.0057 must
1694 be reimbursed by Medicaid for the federal share for a Medicaid-
1695 eligible child who receives Medicaid-covered services in a
1696 school setting, regardless of whether the child is enrolled in a
1697 capitated managed care network. Capitated managed care networks
1698 must make a good faith effort to execute agreements with county
1699 health departments and federally qualified health centers
1700 regarding the coordinated provision of services to a Medicaid-
1701 eligible child. To ensure continuity of care for Medicaid
1702 patients, the agency, the Department of Health, and the
1703 Department of Education shall develop procedures for ensuring
1704 that a student's capitated managed care network provider
1705 receives information relating to services provided in accordance
1706 with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
1707 (aa) To implement a mechanism whereby Medicaid recipients
1708 who are already enrolled in a managed care plan or the MediPass
1709 program in the pilot areas shall be offered the opportunity to
1710 change to capitated managed care plans on a staggered basis, as
1711 defined by the agency. All Medicaid recipients shall have 30
1712 days in which to make a choice of capitated managed care plans.
1713 Those Medicaid recipients who do not make a choice shall be
1714 assigned to a capitated managed care plan in accordance with

1715 paragraph (4)(a) and shall be exempt from s. 409.9122. To
1716 facilitate continuity of care for a Medicaid recipient who is
1717 also a recipient of Supplemental Security Income (SSI), prior to
1718 assigning the SSI recipient to a capitated managed care plan,
1719 the agency shall determine whether the SSI recipient has an
1720 ongoing relationship with a provider or capitated managed care
1721 plan, and, if so, the agency shall assign the SSI recipient to
1722 that provider or capitated managed care plan where feasible.
1723 Those SSI recipients who do not have such a provider
1724 relationship shall be assigned to a capitated managed care plan
1725 provider in accordance with paragraph (4)(a) and shall be exempt
1726 from s. 409.9122.
1727 (bb) To develop and recommend a service delivery
1728 alternative for children having chronic medical conditions which
1729 establishes a medical home project to provide primary care
1730 services to this population. The project shall provide
1731 community-based primary care services that are integrated with
1732 other subspecialties to meet the medical, developmental, and
1733 emotional needs for children and their families. This project
1734 shall include an evaluation component to determine impacts on
1735 hospitalizations, length of stays, emergency room visits, costs,
1736 and access to care, including specialty care and patient and
1737 family satisfaction.
1738 (cc) To develop and recommend service delivery mechanisms
1739 within capitated managed care plans to provide Medicaid services
1740 as specified in ss. 409.905 and 409.906 to persons with
1741 developmental disabilities sufficient to meet the medical,
1742 developmental, and emotional needs of these persons.

1743 (dd) To implement service delivery mechanisms within
1744 capitated managed care plans to provide Medicaid services as
1745 specified in ss. 409.905 and 409.906 to Medicaid-eligible
1746 children whose cases are open for child welfare services in the
1747 HomeSafeNet system. These services must be coordinated with
1748 community-based care providers as specified in s. 409.1671,
1749 where available, and be sufficient to meet the medical,
1750 developmental, behavioral, and emotional needs of these
1751 children. These service delivery mechanisms must be implemented
1752 no later than July 1, 2008, in AHCA area 10 in order for the
1753 children in AHCA area 10 to remain exempt from the statewide
1754 plan under s. 409.912(4)(b)8.
1755 (4)(a) A Medicaid recipient in the pilot area who is not
1756 currently enrolled in a capitated managed care plan upon
1757 implementation is not eligible for services as specified in ss.
1758 409.905 and 409.906, for the amount of time that the recipient
1759 does not enroll in a capitated managed care network. If a
1760 Medicaid recipient has not enrolled in a capitated managed care
1761 plan within 30 days after eligibility, the agency shall assign
1762 the Medicaid recipient to a provider service network. The agency
1763 shall assign such recipients to provider service networks for
1764 the first 5 years of implementation of each demonstration site
1765 or until the number of recipients enrolled in provider service
1766 networks in that demonstration site reaches 10 percent of the
1767 total number of participating Medicaid recipients in that
1768 demonstration site, whichever is first. After that time, if a
1769 Medicaid recipient has not enrolled in a capitated managed care
1770 plan within 30 days after eligibility, the agency shall assign

1771 the Medicaid recipient to a capitated managed care plan based on
1772 the assessed needs of the recipient as determined by the agency,
1773 and the recipient shall be exempt from s. 409.9122. When making
1774 such assignments, the agency shall take into account the
1775 following criteria:
1776 1. A capitated managed care network has sufficient network
1777 capacity to meet the needs of members.
1778 2. The capitated managed care network has previously
1779 enrolled the recipient as a member, or one of the capitated
1780 managed care network's primary care providers has previously
1781 provided health care to the recipient.
1782 3. The agency has knowledge that the member has previously
1783 expressed a preference for a particular capitated managed care
1784 network as indicated by Medicaid fee-for-service claims data,
1785 but has failed to make a choice.
1786 4. The capitated managed care network's primary care
1787 providers are geographically accessible to the recipient's
1788 residence.
1789 (b) When more than one capitated managed care network
1790 provider meets the criteria specified in paragraph (3)(h), the
1791 agency shall make recipient assignments consecutively by family
1792 unit.
1793 (c) If a recipient is currently enrolled with a Medicaid
1794 managed care organization that also operates an approved reform
1795 plan within a demonstration area and the recipient fails to
1796 choose a plan during the reform enrollment process or during
1797 redetermination of eligibility, the recipient shall be
1798 automatically assigned by the agency to a provider service

1799 network. The agency shall assign such recipients to provider
1800 service networks for the first 5 years of implementation of each
1801 demonstration site or until the number of recipients enrolled in
1802 provider service networks in that demonstration site reaches 10
1803 percent of the total number of participating Medicaid recipients
1804 in that demonstration site, whichever is first. After that time
1805 ~~into the most appropriate reform plan operated by the~~
1806 ~~recipient's current Medicaid managed care plan. If the~~
1807 ~~recipient's current managed care plan does not operate a reform~~
1808 ~~plan in the demonstration area which adequately meets the needs~~
1809 ~~of the Medicaid recipient~~, the agency shall use the automatic
1810 assignment process as prescribed in the special terms and
1811 conditions numbered 11-W-00206/4. All enrollment and choice
1812 counseling materials provided by the agency must contain an
1813 explanation of the provisions of this paragraph for current
1814 managed care recipients.
1815 (d) The agency may not engage in practices that are
1816 designed to favor one capitated managed care plan over another
1817 or that are designed to influence Medicaid recipients to enroll
1818 in a particular capitated managed care network in order to
1819 strengthen its particular fiscal viability.
1820 (e) After a recipient has made a selection or has been
1821 enrolled in a capitated managed care network, the recipient
1822 shall have 90 days in which to voluntarily disenroll and select
1823 another capitated managed care network. After 90 days, no
1824 further changes may be made except for cause. Cause shall
1825 include, but not be limited to, poor quality of care, lack of
1826 access to necessary specialty services, an unreasonable delay or

1827 denial of service, inordinate or inappropriate changes of
1828 primary care providers, service access impairments due to
1829 significant changes in the geographic location of services, or
1830 fraudulent enrollment. The agency may require a recipient to use
1831 the capitated managed care network's grievance process as
1832 specified in paragraph (3)(q) prior to the agency's
1833 determination of cause, except in cases in which immediate risk
1834 of permanent damage to the recipient's health is alleged. The
1835 grievance process, when used, must be completed in time to
1836 permit the recipient to disenroll no later than the first day of
1837 the second month after the month the disenrollment request was
1838 made. If the capitated managed care network, as a result of the
1839 grievance process, approves an enrollee's request to disenroll,
1840 the agency is not required to make a determination in the case.
1841 The agency must make a determination and take final action on a
1842 recipient's request so that disenrollment occurs no later than
1843 the first day of the second month after the month the request
1844 was made. If the agency fails to act within the specified
1845 timeframe, the recipient's request to disenroll is deemed to be
1846 approved as of the date agency action was required. Recipients
1847 who disagree with the agency's finding that cause does not exist
1848 for disenrollment shall be advised of their right to pursue a
1849 Medicaid fair hearing to dispute the agency's finding.
1850 (f) The agency shall apply for federal waivers from the
1851 Centers for Medicare and Medicaid Services to lock eligible
1852 Medicaid recipients into a capitated managed care network for 12
1853 months after an open enrollment period. After 12 months of
1854 enrollment, a recipient may select another capitated managed

1855 care network. However, nothing shall prevent a Medicaid
1856 recipient from changing primary care providers within the
1857 capitated managed care network during the 12-month period.
1858 (g) The agency shall apply for federal waivers from the
1859 Centers for Medicare and Medicaid Services to allow recipients
1860 to purchase health care coverage through an employer-sponsored
1861 health insurance plan instead of through a Medicaid-certified
1862 plan. This provision shall be known as the opt-out option.
1863 1. A recipient who chooses the Medicaid opt-out option
1864 shall have an opportunity for a specified period of time, as
1865 authorized under a waiver granted by the Centers for Medicare
1866 and Medicaid Services, to select and enroll in a Medicaid-
1867 certified plan. If the recipient remains in the employer-
1868 sponsored plan after the specified period, the recipient shall
1869 remain in the opt-out program for at least 1 year or until the
1870 recipient no longer has access to employer-sponsored coverage,
1871 until the employer's open enrollment period for a person who
1872 opts out in order to participate in employer-sponsored coverage,
1873 or until the person is no longer eligible for Medicaid,
1874 whichever time period is shorter.
1875 2. Notwithstanding any other provision of this section,
1876 coverage, cost sharing, and any other component of employer-
1877 sponsored health insurance shall be governed by applicable state
1878 and federal laws.
1879 (5) This section does not authorize the agency to
1880 implement any provision of s. 1115 of the Social Security Act
1881 experimental, pilot, or demonstration project waiver to reform
1882 the state Medicaid program in any part of the state other than

1883 the two geographic areas specified in this section unless
1884 approved by the Legislature.
1885 (6) The agency shall develop and submit for approval
1886 applications for waivers of applicable federal laws and
1887 regulations as necessary to implement the managed care pilot
1888 project as defined in this section. The agency shall post all
1889 waiver applications under this section on its Internet website
1890 30 days before submitting the applications to the United States
1891 Centers for Medicare and Medicaid Services. All waiver
1892 applications shall be provided for review and comment to the
1893 appropriate committees of the Senate and House of
1894 Representatives for at least 10 working days prior to
1895 submission. All waivers submitted to and approved by the United
1896 States Centers for Medicare and Medicaid Services under this
1897 section must be approved by the Legislature. Federally approved
1898 waivers must be submitted to the President of the Senate and the
1899 Speaker of the House of Representatives for referral to the
1900 appropriate legislative committees. The appropriate committees
1901 shall recommend whether to approve the implementation of any
1902 waivers to the Legislature as a whole. The agency shall submit a
1903 plan containing a recommended timeline for implementation of any
1904 waivers and budgetary projections of the effect of the pilot
1905 program under this section on the total Medicaid budget for the
1906 2006-2007 through 2009-2010 state fiscal years. This
1907 implementation plan shall be submitted to the President of the
1908 Senate and the Speaker of the House of Representatives at the
1909 same time any waivers are submitted for consideration by the
1910 Legislature. The agency may implement the waiver and special

1911 terms and conditions numbered 11-W-00206/4, as approved by the
1912 federal Centers for Medicare and Medicaid Services. If the
1913 agency seeks approval by the Federal Government of any
1914 modifications to these special terms and conditions, the agency
1915 must provide written notification of its intent to modify these
1916 terms and conditions to the President of the Senate and the
1917 Speaker of the House of Representatives at least 15 days before
1918 submitting the modifications to the Federal Government for
1919 consideration. The notification must identify all modifications
1920 being pursued and the reason the modifications are needed. Upon
1921 receiving federal approval of any modifications to the special
1922 terms and conditions, the agency shall provide a report to the
1923 Legislature describing the federally approved modifications to
1924 the special terms and conditions within 7 days after approval by
1925 the Federal Government.
1926 (7)(a) The Secretary of Health Care Administration shall
1927 convene a technical advisory panel to advise the agency in the
1928 areas of risk-adjusted-rate setting, benefit design, and choice
1929 counseling. The panel shall include representatives from the
1930 Florida Association of Health Plans, representatives from
1931 provider-sponsored networks, a Medicaid consumer representative,
1932 and a representative from the Office of Insurance Regulation.
1933 (b) The technical advisory panel shall advise the agency
1934 concerning:
1935 1. The risk-adjusted rate methodology to be used by the
1936 agency, including recommendations on mechanisms to recognize the
1937 risk of all Medicaid enrollees and for the transition to a risk-

1938 adjustment system, including recommendations for phasing in risk
1939 adjustment and the use of risk corridors.
1940 2. Implementation of an encounter data system to be used
1941 for risk-adjusted rates.
1942 3. Administrative and implementation issues regarding the
1943 use of risk-adjusted rates, including, but not limited to, cost,
1944 simplicity, client privacy, data accuracy, and data exchange.
1945 4. Issues of benefit design, including the actuarial
1946 equivalence and sufficiency standards to be used.
1947 5. The implementation plan for the proposed choice-
1948 counseling system, including the information and materials to be
1949 provided to recipients, the methodologies by which recipients
1950 will be counseled regarding choice, criteria to be used to
1951 assess plan quality, the methodology to be used to assign
1952 recipients into plans if they fail to choose a managed care
1953 plan, and the standards to be used for responsiveness to
1954 recipient inquiries.
1955 (c) The technical advisory panel shall continue in
1956 existence and advise the agency on matters outlined in this
1957 subsection.
1958 (8) The agency must ensure, in the first two state fiscal
1959 years in which a risk-adjusted methodology is a component of
1960 rate setting, that no managed care plan providing comprehensive
1961 benefits to TANF and SSI recipients has an aggregate risk score
1962 that varies by more than 10 percent from the aggregate weighted
1963 mean of all managed care plans providing comprehensive benefits
1964 to TANF and SSI recipients in a reform area. The agency's

1965 payment to a managed care plan shall be based on such revised
1966 aggregate risk score.
1967 (9) After any calculations of aggregate risk scores or
1968 revised aggregate risk scores in subsection (8), the capitation
1969 rates for plans participating under this section shall be phased
1970 in as follows:
1971 (a) In the first year, the capitation rates shall be
1972 weighted so that 75 percent of each capitation rate is based on
1973 the current methodology and 25 percent is based on a new risk-
1974 adjusted capitation rate methodology.
1975 (b) In the second year, the capitation rates shall be
1976 weighted so that 50 percent of each capitation rate is based on
1977 the current methodology and 50 percent is based on a new risk-
1978 adjusted rate methodology.
1979 (c) In the following fiscal year, the risk-adjusted
1980 capitation methodology may be fully implemented.
1981 (10) Subsections (8) and (9) do not apply to managed care
1982 plans offering benefits exclusively to high-risk, specialty
1983 populations. The agency may set risk-adjusted rates immediately
1984 for such plans.
1985 (11) Before the implementation of risk-adjusted rates, the
1986 rates shall be certified by an actuary and approved by the
1987 federal Centers for Medicare and Medicaid Services.
1988 (12) For purposes of this section, the term "capitated
1989 managed care plan" includes health insurers authorized under
1990 chapter 624, exclusive provider organizations authorized under
1991 chapter 627, health maintenance organizations authorized under
1992 chapter 641, the Children's Medical Services Network under

1993 chapter 391, and provider service networks that elect to be paid
1994 fee-for-service for up to 3 years as authorized under this
1995 section.
1996 (13) Upon review and approval of the applications for
1997 waivers of applicable federal laws and regulations to implement
1998 the managed care pilot program by the Legislature, the agency
1999 may initiate adoption of rules pursuant to ss. 120.536(1) and
2000 120.54 to implement and administer the managed care pilot
2001 program as provided in this section.
2002 (14) It is the intent of the Legislature that if any
2003 conflict exists between the provisions contained in this section
2004 and other provisions of this chapter which relate to the
2005 implementation of the Medicaid managed care pilot program, the
2006 provisions contained in this section shall control. The agency
2007 shall provide a written report to the Legislature by April 1,
2008 2006, identifying any provisions of this chapter which conflict
2009 with the implementation of the Medicaid managed care pilot
2010 program created in this section. After April 1, 2006, the agency
2011 shall provide a written report to the Legislature immediately
2012 upon identifying any provisions of this chapter which conflict
2013 with the implementation of the Medicaid managed care pilot
2014 program created in this section.
2015 Section 13. Subsection (2) of section 409.9124, Florida
2016 Statutes, is amended to read:
2017 409.9124 Managed care reimbursement.--The agency shall
2018 develop and adopt by rule a methodology for reimbursing managed
2019 care plans.

2020 (2) Each year prior to establishing new managed care
2021 rates, the agency shall review all prior year adjustments for
2022 changes in trend, and shall reduce or eliminate those
2023 adjustments which are not reasonable and which reflect policies
2024 or programs which are not in effect. In addition, the agency
2025 shall apply only those policy reductions applicable to the
2026 fiscal year for which the rates are being set, which can be
2027 accurately estimated and verified by an independent actuary, and
2028 which have been implemented prior to or will be implemented
2029 during the fiscal year. ~~The agency shall pay rates at per-~~
2030 ~~member, per-month averages that do not exceed the amounts~~
2031 ~~allowed for in the General Appropriations Act applicable to the~~
2032 ~~fiscal year for which the rates will be in effect.~~
2033 Section 14. Subsection (36) of section 409.913, Florida
2034 Statutes, is amended to read:
2035 409.913 Oversight of the integrity of the Medicaid
2036 program.--The agency shall operate a program to oversee the
2037 activities of Florida Medicaid recipients, and providers and
2038 their representatives, to ensure that fraudulent and abusive
2039 behavior and neglect of recipients occur to the minimum extent
2040 possible, and to recover overpayments and impose sanctions as
2041 appropriate. Beginning January 1, 2003, and each year
2042 thereafter, the agency and the Medicaid Fraud Control Unit of
2043 the Department of Legal Affairs shall submit a joint report to
2044 the Legislature documenting the effectiveness of the state's
2045 efforts to control Medicaid fraud and abuse and to recover
2046 Medicaid overpayments during the previous fiscal year. The
2047 report must describe the number of cases opened and investigated

2048 each year; the sources of the cases opened; the disposition of
2049 the cases closed each year; the amount of overpayments alleged
2050 in preliminary and final audit letters; the number and amount of
2051 fines or penalties imposed; any reductions in overpayment
2052 amounts negotiated in settlement agreements or by other means;
2053 the amount of final agency determinations of overpayments; the
2054 amount deducted from federal claiming as a result of
2055 overpayments; the amount of overpayments recovered each year;
2056 the amount of cost of investigation recovered each year; the
2057 average length of time to collect from the time the case was
2058 opened until the overpayment is paid in full; the amount
2059 determined as uncollectible and the portion of the uncollectible
2060 amount subsequently reclaimed from the Federal Government; the
2061 number of providers, by type, that are terminated from
2062 participation in the Medicaid program as a result of fraud and
2063 abuse; and all costs associated with discovering and prosecuting
2064 cases of Medicaid overpayments and making recoveries in such
2065 cases. The report must also document actions taken to prevent
2066 overpayments and the number of providers prevented from
2067 enrolling in or reenrolling in the Medicaid program as a result
2068 of documented Medicaid fraud and abuse and must recommend
2069 changes necessary to prevent or recover overpayments.
2070 (36) The agency shall provide to each Medicaid recipient
2071 or his or her representative an explanation of benefits in the
2072 form of a letter that is mailed to the most recent address of
2073 the recipient on the record with the Department of Children and
2074 Family Services. The explanation of benefits must include the
2075 patient's name, the name of the health care provider and the

2076 address of the location where the service was provided, a
2077 description of all services billed to Medicaid in terminology
2078 that should be understood by a reasonable person, and
2079 information on how to report inappropriate or incorrect billing
2080 to the agency or other law enforcement entities for review or
2081 investigation. <u>The explanation of benefits may not be mailed for</u>
2082 <u>Medicaid independent laboratory services as described in s.</u>
2083 <u>409.905(7) or for Medicaid certified match services as described</u>
2084 <u>in ss. 409.9071 and 1011.70.</u>
2085 Section 15. Paragraph (a) of subsection (8) of section
2086 39.001, Florida Statutes, is amended to read:
2087 39.001 Purposes and intent; personnel standards and
2088 screening.--
2089 (8) PLAN FOR COMPREHENSIVE APPROACH.--
2090 (a) The office shall develop a state plan for the
2091 promotion of adoption, support of adoptive families, and
2092 prevention of abuse, abandonment, and neglect of children and
2093 shall submit the state plan to the Speaker of the House of
2094 Representatives, the President of the Senate, and the Governor
2095 no later than December 31, 2008. The Department of Children and
2096 Family Services, the Department of Corrections, the Department
2097 of Education, the Department of Health, the Department of
2098 Juvenile Justice, the Department of Law Enforcement, the Agency
2099 for Persons with Disabilities, and the Agency for Workforce
2100 Innovation shall participate and fully cooperate in the
2101 development of the state plan at both the state and local
2102 levels. Furthermore, appropriate local agencies and
2103 organizations shall be provided an opportunity to participate in

2104 the development of the state plan at the local level.
2105 Appropriate local groups and organizations shall include, but
2106 not be limited to, community mental health centers; guardian ad
2107 litem programs for children under the circuit court; the school
2108 boards of the local school districts; ~~the Florida local advocacy~~
2109 ~~councils;~~ community-based care lead agencies; private or public
2110 organizations or programs with recognized expertise in working
2111 with child abuse prevention programs for children and families;
2112 private or public organizations or programs with recognized
2113 expertise in working with children who are sexually abused,
2114 physically abused, emotionally abused, abandoned, or neglected
2115 and with expertise in working with the families of such
2116 children; private or public programs or organizations with
2117 expertise in maternal and infant health care; multidisciplinary
2118 child protection teams; child day care centers; law enforcement
2119 agencies; and the circuit courts, when guardian ad litem
2120 programs are not available in the local area. The state plan to
2121 be provided to the Legislature and the Governor shall include,
2122 as a minimum, the information required of the various groups in
2123 paragraph (b).
2124 Section 16. Subsection (2) of section 39.0011, Florida
2125 Statutes, is amended to read:
2126 39.0011 Direct-support organization.--
2127 (2) The number of members on the board of directors of the
2128 direct-support organization shall be determined by the Chief
2129 Child Advocate. Membership on the board of directors of the
2130 direct-support organization shall include, but not be limited
2131 to, a guardian ad litem; ~~a member of a local advocacy council;~~ a

2132 representative from a community-based care lead agency; a
2133 representative from a private or public organization or program
2134 with recognized expertise in working with child abuse prevention
2135 programs for children and families; a representative of a
2136 private or public organization or program with recognized
2137 expertise in working with children who are sexually abused,
2138 physically abused, emotionally abused, abandoned, or neglected
2139 and with expertise in working with the families of such
2140 children; an individual working at a state adoption agency; and
2141 the parent of a child adopted from within the child welfare
2142 system.
2143 Section 17. Paragraph (k) of subsection (2) of section
2144 39.202, Florida Statutes, is amended to read:
2145 39.202 Confidentiality of reports and records in cases of
2146 child abuse or neglect.--
2147 (2) Except as provided in subsection (4), access to such
2148 records, excluding the name of the reporter which shall be
2149 released only as provided in subsection (5), shall be granted
2150 only to the following persons, officials, and agencies:
2151 (k) ~~Any appropriate official of a Florida advocacy council~~
2152 ~~investigating a report of known or suspected child abuse,~~
2153 ~~abandonment, or neglect;~~ The Auditor General or the Office of
2154 Program Policy Analysis and Government Accountability for the
2155 purpose of conducting audits or examinations pursuant to law~~;~~ or
2156 the guardian ad litem for the child.
2157 Section 18. Subsections (5), (6), and (7) of section
2158 39.302, Florida Statutes, are renumbered as subsections (4),

2159 (5), and (6), respectively, and present subsection (4) is
2160 amended to read:
2161 39.302 Protective investigations of institutional child
2162 abuse, abandonment, or neglect.--
2163 ~~(4) The department shall notify the Florida local advocacy~~
2164 ~~council in the appropriate district of the department as to~~
2165 ~~every report of institutional child abuse, abandonment, or~~
2166 ~~neglect in the district in which a client of the department is~~
2167 ~~alleged or shown to have been abused, abandoned, or neglected,~~
2168 ~~which notification shall be made within 48 hours after the~~
2169 ~~department commences its investigation.~~
2170 Section 19. Paragraph (v) of subsection (1) of section
2171 215.22, Florida Statutes, is redesignated as paragraph (u), and
2172 present paragraph (u) of that subsection is amended to read:
2173 215.22 Certain income and certain trust funds exempt.--
2174 (1) The following income of a revenue nature or the
2175 following trust funds shall be exempt from the appropriation
2176 required by s. 215.20(1):
2177 ~~(u) The Florida Center for Nursing Trust Fund.~~
2178 Section 20. Paragraph (c) of subsection (5) and subsection
2179 (12) of section 394.459, Florida Statutes, are amended to read:
2180 394.459 Rights of patients.--
2181 (5) COMMUNICATION, ABUSE REPORTING, AND VISITS.--
2182 (c) Each facility must permit immediate access to any
2183 patient, subject to the patient's right to deny or withdraw
2184 consent at any time, by the patient's family members, guardian,
2185 guardian advocate, representative, ~~Florida statewide or local~~
2186 ~~advocacy council,~~ or attorney, unless such access would be

2187 detrimental to the patient. If a patient's right to communicate
2188 or to receive visitors is restricted by the facility, written
2189 notice of such restriction and the reasons for the restriction
2190 shall be served on the patient, the patient's attorney, and the
2191 patient's guardian, guardian advocate, or representative; and
2192 such restriction shall be recorded on the patient's clinical
2193 record with the reasons therefor. The restriction of a patient's
2194 right to communicate or to receive visitors shall be reviewed at
2195 least every 7 days. The right to communicate or receive visitors
2196 shall not be restricted as a means of punishment. Nothing in
2197 this paragraph shall be construed to limit the provisions of
2198 paragraph (d).
2199 (12) POSTING OF NOTICE OF RIGHTS OF PATIENTS.--Each
2200 facility shall post a notice listing and describing, in the
2201 language and terminology that the persons to whom the notice is
2202 addressed can understand, the rights provided in this section.
2203 This notice shall include a statement that provisions of the
2204 federal Americans with Disabilities Act apply and the name and
2205 telephone number of a person to contact for further information.
2206 This notice shall be posted in a place readily accessible to
2207 patients and in a format easily seen by patients. This notice
2208 shall include the telephone number ~~numbers~~ of the ~~Florida local~~
2209 ~~advocacy council and~~ Advocacy Center for Persons with
2210 Disabilities, Inc.
2211 Section 21. Paragraph (d) of subsection (2) of section
2212 394.4597, Florida Statutes, is amended to read:
2213 394.4597 Persons to be notified; patient's
2214 representative.--

2215 (2) INVOLUNTARY PATIENTS.--
2216 (d) When the receiving or treatment facility selects a
2217 representative, first preference shall be given to a health care
2218 surrogate, if one has been previously selected by the patient.
2219 If the patient has not previously selected a health care
2220 surrogate, the selection, except for good cause documented in
2221 the patient's clinical record, shall be made from the following
2222 list in the order of listing:
2223 1. The patient's spouse.
2224 2. An adult child of the patient.
2225 3. A parent of the patient.
2226 4. The adult next of kin of the patient.
2227 5. An adult friend of the patient.
2228 ~~6. The appropriate Florida local advocacy council as~~
2229 ~~provided in s. 402.166.~~
2230 Section 22. Subsection (1) of section 394.4598, Florida
2231 Statutes, is amended to read:
2232 394.4598 Guardian advocate.--
2233 (1) The administrator may petition the court for the
2234 appointment of a guardian advocate based upon the opinion of a
2235 psychiatrist that the patient is incompetent to consent to
2236 treatment. If the court finds that a patient is incompetent to
2237 consent to treatment and has not been adjudicated incapacitated
2238 and a guardian with the authority to consent to mental health
2239 treatment appointed, it shall appoint a guardian advocate. The
2240 patient has the right to have an attorney represent him or her
2241 at the hearing. If the person is indigent, the court shall
2242 appoint the office of the public defender to represent him or

2243 her at the hearing. The patient has the right to testify, cross-
2244 examine witnesses, and present witnesses. The proceeding shall
2245 be recorded either electronically or stenographically, and
2246 testimony shall be provided under oath. One of the professionals
2247 authorized to give an opinion in support of a petition for
2248 involuntary placement, as described in s. 394.4655 or s.
2249 394.467, must testify. A guardian advocate must meet the
2250 qualifications of a guardian contained in part IV of chapter
2251 744, except that a professional referred to in this part, an
2252 employee of the facility providing direct services to the
2253 patient under this part, a departmental employee, <u>or</u> a facility
2254 administrator~~, or member of the Florida local advocacy council~~
2255 shall not be appointed. A person who is appointed as a guardian
2256 advocate must agree to the appointment.
2257 Section 23. Paragraph (b) of subsection (2) of section
2258 394.4599, Florida Statutes, is amended to read:
2259 394.4599 Notice.--
2260 (2) INVOLUNTARY PATIENTS.--
2261 (b) A receiving facility shall give prompt notice of the
2262 whereabouts of a patient who is being involuntarily held for
2263 examination, by telephone or in person within 24 hours after the
2264 patient's arrival at the facility, unless the patient requests
2265 that no notification be made. Contact attempts shall be
2266 documented in the patient's clinical record and shall begin as
2267 soon as reasonably possible after the patient's arrival. ~~Notice~~
2268 ~~that a patient is being admitted as an involuntary patient shall~~
2269 ~~be given to the Florida local advocacy council no later than the~~
2270 ~~next working day after the patient is admitted.~~

2271 Section 24. Subsections (6) through (11) of section
2272 394.4615, Florida Statutes, are renumbered as subsections (5)
2273 through (10), respectively, and present subsection (5) is
2274 amended to read:
2275 394.4615 Clinical records; confidentiality.--
2276 ~~(5) Information from clinical records may be used by the~~
2277 ~~Agency for Health Care Administration, the department, and the~~
2278 ~~Florida advocacy councils for the purpose of monitoring facility~~
2279 ~~activity and complaints concerning facilities.~~
2280 Section 25. Paragraphs (h) and (i) of subsection (2) of
2281 section 400.0065, Florida Statutes, are redesignated as
2282 paragraphs (g) and (h), respectively, and present paragraph (g)
2283 of that subsection is amended to read:
2284 400.0065 State Long-Term Care Ombudsman; duties and
2285 responsibilities.--
2286 (2) The State Long-Term Care Ombudsman shall have the duty
2287 and authority to:
2288 ~~(g) Enter into a cooperative agreement with the Statewide~~
2289 ~~Advocacy Council for the purpose of coordinating and avoiding~~
2290 ~~duplication of advocacy services provided to residents.~~
2291 Section 26. Paragraph (a) of subsection (2) of section
2292 400.118, Florida Statutes, is amended to read:
2293 400.118 Quality assurance; early warning system;
2294 monitoring; rapid response teams.--
2295 (2)(a) The agency shall establish within each district
2296 office one or more quality-of-care monitors, based on the number
2297 of nursing facilities in the district, to monitor all nursing
2298 facilities in the district on a regular, unannounced, aperiodic

2299 basis, including nights, evenings, weekends, and holidays.
2300 Quality-of-care monitors shall visit each nursing facility at
2301 least quarterly. Priority for additional monitoring visits shall
2302 be given to nursing facilities with a history of resident care
2303 deficiencies. Quality-of-care monitors shall be registered
2304 nurses who are trained and experienced in nursing facility
2305 regulation, standards of practice in long-term care, and
2306 evaluation of patient care. Individuals in these positions shall
2307 not be deployed by the agency as a part of the district survey
2308 team in the conduct of routine, scheduled surveys, but shall
2309 function solely and independently as quality-of-care monitors.
2310 Quality-of-care monitors shall assess the overall quality of
2311 life in the nursing facility and shall assess specific
2312 conditions in the facility directly related to resident care,
2313 including the operations of internal quality improvement and
2314 risk management programs and adverse incident reports. The
2315 quality-of-care monitor shall include in an assessment visit
2316 observation of the care and services rendered to residents and
2317 formal and informal interviews with residents, family members,
2318 facility staff, resident guests, volunteers, other regulatory
2319 staff, and representatives of a long-term care ombudsman council
2320 ~~or Florida advocacy council~~.
2321 Section 27. Subsections (13) and (20) of section 400.141,
2322 Florida Statutes, are amended to read:
2323 400.141 Administration and management of nursing home
2324 facilities.--Every licensed facility shall comply with all
2325 applicable standards and rules of the agency and shall:

2326 (13) Publicly display a poster provided by the agency
2327 containing the names, addresses, and telephone numbers for the
2328 state's abuse hotline, the State Long-Term Care Ombudsman, the
2329 Agency for Health Care Administration consumer hotline, the
2330 Advocacy Center for Persons with Disabilities, ~~the Florida~~
2331 ~~Statewide Advocacy Council,~~ and the Medicaid Fraud Control Unit,
2332 with a clear description of the assistance to be expected from
2333 each.
2334 (20) Maintain general and professional liability insurance
2335 coverage that is in force at all times. ~~In lieu of general and~~
2336 ~~professional liability insurance coverage, a state-designated~~
2337 ~~teaching nursing home and its affiliated assisted living~~
2338 ~~facilities created under s. 430.80 may demonstrate proof of~~
2339 ~~financial responsibility as provided in s. 430.80(3)(h).~~
2340
2341 Facilities that have been awarded a Gold Seal under the program
2342 established in s. 400.235 may develop a plan to provide
2343 certified nursing assistant training as prescribed by federal
2344 regulations and state rules and may apply to the agency for
2345 approval of their program.
2346 Section 28. Paragraph (a) of subsection (1) of section
2347 415.1034, Florida Statutes, is amended to read:
2348 415.1034 Mandatory reporting of abuse, neglect, or
2349 exploitation of vulnerable adults; mandatory reports of death.--
2350 (1) MANDATORY REPORTING.--
2351 (a) Any person, including, but not limited to, any:
2352 1. Physician, osteopathic physician, medical examiner,
2353 chiropractic physician, nurse, paramedic, emergency medical

2354 technician, or hospital personnel engaged in the admission,
2355 examination, care, or treatment of vulnerable adults;
2356 2. Health professional or mental health professional other
2357 than one listed in subparagraph 1.;
2358 3. Practitioner who relies solely on spiritual means for
2359 healing;
2360 4. Nursing home staff; assisted living facility staff;
2361 adult day care center staff; adult family-care home staff;
2362 social worker; or other professional adult care, residential, or
2363 institutional staff;
2364 5. State, county, or municipal criminal justice employee
2365 or law enforcement officer;
2366 6. An employee of the Department of Business and
2367 Professional Regulation conducting inspections of public lodging
2368 establishments under s. 509.032;
2369 7. ~~Florida advocacy council member or~~ Long-term care
2370 ombudsman council member; or
2371 8. Bank, savings and loan, or credit union officer,
2372 trustee, or employee,
2373
2374 who knows, or has reasonable cause to suspect, that a vulnerable
2375 adult has been or is being abused, neglected, or exploited shall
2376 immediately report such knowledge or suspicion to the central
2377 abuse hotline.
2378 Section 29. Subsection (1) of section 415.104, Florida
2379 Statutes, is amended to read:

2380 415.104 Protective investigations of cases of abuse,
2381 neglect, or exploitation of vulnerable adults; transmittal of
2382 records to state attorney.--
2383 (1) The department shall, upon receipt of a report
2384 alleging abuse, neglect, or exploitation of a vulnerable adult,
2385 begin within 24 hours a protective investigation of the facts
2386 alleged therein. If a caregiver refuses to allow the department
2387 to begin a protective investigation or interferes with the
2388 conduct of such an investigation, the appropriate law
2389 enforcement agency shall be contacted for assistance. If, during
2390 the course of the investigation, the department has reason to
2391 believe that the abuse, neglect, or exploitation is perpetrated
2392 by a second party, the appropriate law enforcement agency and
2393 state attorney shall be orally notified. The department and the
2394 law enforcement agency shall cooperate to allow the criminal
2395 investigation to proceed concurrently with, and not be hindered
2396 by, the protective investigation. The department shall make a
2397 preliminary written report to the law enforcement agencies
2398 within 5 working days after the oral report. The department
2399 shall, within 24 hours after receipt of the report, notify the
2400 ~~appropriate Florida local advocacy council, or~~ long-term care
2401 ombudsman council, when appropriate, that an alleged abuse,
2402 neglect, or exploitation perpetrated by a second party has
2403 occurred. Notice to the ~~Florida local advocacy council or~~ long-
2404 term care ombudsman council may be accomplished orally or in
2405 writing and shall include the name and location of the
2406 vulnerable adult alleged to have been abused, neglected, or
2407 exploited and the nature of the report.

2408 Section 30. Subsection (8) of section 415.1055, Florida
2409 Statutes, is amended to read:
2410 415.1055 Notification to administrative entities.--
2411 (8) At the conclusion of a protective investigation at a
2412 facility, the department shall notify ~~either~~ the ~~Florida local~~
2413 ~~advocacy council or~~ long-term care ombudsman council of the
2414 results of the investigation. This notification must be in
2415 writing.
2416 Section 31. Subsection (2) of section 415.106, Florida
2417 Statutes, is amended to read:
2418 415.106 Cooperation by the department and criminal justice
2419 and other agencies.--
2420 (2) To ensure coordination, communication, and cooperation
2421 with the investigation of abuse, neglect, or exploitation of
2422 vulnerable adults, the department shall develop and maintain
2423 interprogram agreements or operational procedures among
2424 appropriate departmental programs and the State Long-Term Care
2425 Ombudsman Council~~, the Florida Statewide Advocacy Council,~~ and
2426 other agencies that provide services to vulnerable adults. These
2427 agreements or procedures must cover such subjects as the
2428 appropriate roles and responsibilities of the department in
2429 identifying and responding to reports of abuse, neglect, or
2430 exploitation of vulnerable adults; the provision of services;
2431 and related coordinated activities.
2432 Section 32. Paragraph (g) of subsection (3) of section
2433 415.107, Florida Statutes, is amended to read:
2434 415.107 Confidentiality of reports and records.--

2435 (3) Access to all records, excluding the name of the
2436 reporter which shall be released only as provided in subsection
2437 (6), shall be granted only to the following persons, officials,
2438 and agencies:
2439 (g) Any appropriate official of the ~~Florida advocacy~~
2440 ~~council or~~ long-term care ombudsman council investigating a
2441 report of known or suspected abuse, neglect, or exploitation of
2442 a vulnerable adult.
2443 Section 33. Subsection (9) of section 429.19, Florida
2444 Statutes, is amended to read:
2445 429.19 Violations; imposition of administrative fines;
2446 grounds.--
2447 (9) The agency shall develop and disseminate an annual
2448 list of all facilities sanctioned or fined $5,000 or more for
2449 violations of state standards, the number and class of
2450 violations involved, the penalties imposed, and the current
2451 status of cases. The list shall be disseminated, at no charge,
2452 to the Department of Elderly Affairs, the Department of Health,
2453 the Department of Children and Family Services, the Agency for
2454 Persons with Disabilities, the area agencies on aging, ~~the~~
2455 ~~Florida Statewide Advocacy Council,~~ and the state and local
2456 ombudsman councils. The Department of Children and Family
2457 Services shall disseminate the list to service providers under
2458 contract to the department who are responsible for referring
2459 persons to a facility for residency. The agency may charge a fee
2460 commensurate with the cost of printing and postage to other
2461 interested parties requesting a copy of this list.

2462 Section 34. Subsection (2) of section 429.28, Florida
2463 Statutes, is amended to read:
2464 429.28 Resident bill of rights.--
2465 (2) The administrator of a facility shall ensure that a
2466 written notice of the rights, obligations, and prohibitions set
2467 forth in this part is posted in a prominent place in each
2468 facility and read or explained to residents who cannot read.
2469 This notice shall include the name, address, and telephone
2470 numbers of the local ombudsman council and central abuse hotline
2471 and, when applicable, and the Advocacy Center for Persons with
2472 Disabilities, Inc., ~~and the Florida local advocacy council,~~
2473 where complaints may be lodged. The facility must ensure a
2474 resident's access to a telephone to call the local ombudsman
2475 council, central abuse hotline, and the Advocacy Center for
2476 Persons with Disabilities, Inc.~~, and the Florida local advocacy~~
2477 ~~council.~~
2478 Section 35. Section 429.34, Florida Statutes, is amended
2479 to read:
2480 429.34 Right of entry and inspection.--In addition to the
2481 requirements of s. 408.811, any duly designated officer or
2482 employee of the department, the Department of Children and
2483 Family Services, the Medicaid Fraud Control Unit of the Office
2484 of the Attorney General, the state or local fire marshal, or a
2485 member of the state or local long-term care ombudsman council
2486 shall have the right to enter unannounced upon and into the
2487 premises of any facility licensed pursuant to this part in order
2488 to determine the state of compliance with the provisions of this
2489 part, part II of chapter 408, and applicable rules. Data

2490 collected by the state or local long-term care ombudsman
2491 councils ~~or the state or local advocacy councils~~ may be used by
2492 the agency in investigations involving violations of regulatory
2493 standards.
2494 Section 36. Subsection (3) of section 430.04, Florida
2495 Statutes, is amended to read:
2496 430.04 Duties and responsibilities of the Department of
2497 Elderly Affairs.--The Department of Elderly Affairs shall:
2498 (3) Prepare and submit to the Governor, each Cabinet
2499 member, the President of the Senate, the Speaker of the House of
2500 Representatives, the minority leaders of the House and Senate,
2501 and chairpersons of appropriate House and Senate committees a
2502 master plan for policies and programs in the state related to
2503 aging. The plan must identify and assess the needs of the
2504 elderly population in the areas of housing, employment,
2505 education and training, medical care, long-term care, preventive
2506 care, protective services, social services, mental health,
2507 transportation, and long-term care insurance, and other areas
2508 considered appropriate by the department. The plan must assess
2509 the needs of particular subgroups of the population and evaluate
2510 the capacity of existing programs, both public and private and
2511 in state and local agencies, to respond effectively to
2512 identified needs. If the plan recommends the transfer of any
2513 program or service from the Department of Children and Family
2514 Services to another state department, the plan must also include
2515 recommendations that provide for an independent third-party
2516 mechanism~~, as currently exists in the Florida advocacy councils~~
2517 ~~established in ss. 402.165 and 402.166,~~ for protecting the

2518 constitutional and human rights of recipients of departmental
2519 services. The plan must include policy goals and program
2520 strategies designed to respond efficiently to current and
2521 projected needs. The plan must also include policy goals and
2522 program strategies to promote intergenerational relationships
2523 and activities. Public hearings and other appropriate processes
2524 shall be utilized by the department to solicit input for the
2525 development and updating of the master plan from parties
2526 including, but not limited to, the following:
2527 (a) Elderly citizens and their families and caregivers.
2528 (b) Local-level public and private service providers,
2529 advocacy organizations, and other organizations relating to the
2530 elderly.
2531 (c) Local governments.
2532 (d) All state agencies that provide services to the
2533 elderly.
2534 (e) University centers on aging.
2535 (f) Area agency on aging and community care for the
2536 elderly lead agencies.
2537 Section 37. Sections 381.0271, 381.0273, 394.4595,
2538 402.164, 402.165, 402.166, 402.167, 409.9061, 430.80, 430.83,
2539 464.0195, 464.0196, 464.0197, and 464.0198, Florida Statutes,
2540 are repealed.
2541 Section 38. This act shall take effect July 1, 2008.