CHAPTER 2015-3

Senate Bill No. 704

An act relating to the Florida Statutes; repealing ss. 88.7011, 120.745, 163.336, 218.077(5), 220.33(7), 253.01(2)(b), 288.106(4)(f), 339.08(1)(n), 381.0407, 403.709(1)(f), 409.911(10), 409.91211, 430.04(15), 430.502(10)-(12), 443.131(5), 624.351, 624.352, and 626.2815(7), F.S., and amending ss. 110.123, 339.135, 409.912, 409.9122, 576.061, 828.27, and 1002.32, F.S., to delete provisions which have become inoperative by noncurrent repeal or expiration and, pursuant to s. 11.242(5)(b) and (i), F.S., may be omitted from the 2015 Florida Statutes only through a reviser's bill duly enacted by the Legislature; amending ss. 409.91195, 409.91196, 409.962, 636.0145, 641.19, 641.225, and 641.386, F.S., to conform cross-references; providing an effective date.

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

Section 1. Section 88.7011, Florida Statutes, is repealed.

Reviser's note.—Repealed to conform to s. 58, ch. 2011-92, Laws of Florida, which repealed s. 88.7011 effective on a date contingent upon the provisions of s. 81, ch. 2011-92. Section 81, ch. 2011-92, provides that "[e]xcept as otherwise expressly provided in this act, this act shall take effect upon the earlier of 90 days following Congress amending 42 U.S.C. s. 666(f) to allow or require states to adopt the 2008 version of the Uniform Interstate Family Support Act, or 90 days following the state obtaining a waiver of its state plan requirement under Title IV-D of the Social Security Act." Public Law No. 113-183 was signed by the President on September 29, 2014; a portion of that law requires that the 2008 version of the Uniform Interstate Family Support Act is required.

Section 2. Paragraph (g) of subsection (3) of section 110.123, Florida Statutes, is amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(g) Participation by individuals in the program is available to all state officers, full-time state employees, and part-time state employees and is voluntary. Participation in the program is also available to retired state officers and employees who elect at the time of retirement to continue coverage under the program, but may elect to continue all or only part of the coverage they had at the time of retirement. A surviving spouse may elect to continue coverage only under a state group health insurance plan, a TRICARE supplemental insurance plan, or a health maintenance organization plan.

~~1. Full-time state employees described in subparagraph (2)(c)1. are eligible for health insurance coverage in calendar year 2014 as long as they remain employed by an employer participating in the state group insurance program during the year. This subparagraph expires December 31, 2014.~~

~~2. Employees paid from other personal services (OPS) funds are not eligible for coverage before January 1, 2014.~~

Reviser's note.—Amended to delete subparagraph (3)(g)1., which expired pursuant to its own terms, effective December 31, 2014, and to delete subparagraph (3)(g)2. to repeal a provision that has served its purpose.

Section 3. Section 120.745, Florida Statutes, is repealed.

Reviser's note.—The cited section, which relates to legislative review of agency rules in effect on or before November 16, 2010, was repealed pursuant to its own terms, effective July 1, 2014.

Section 4. Section 163.336, Florida Statutes, is repealed.

Reviser's note.—The cited section, which relates to the coastal resort area redevelopment pilot project, expired pursuant to its own terms, effective December 31, 2014.

Section 5. Subsection (5) of section 218.077, Florida Statutes, is repealed.

Reviser's note.—The cited subsection, which relates to the Employer-Sponsored Benefits Study Task Force, was repealed pursuant to its own terms, effective June 30, 2014.

Section 6. Subsection (7) of section 220.33, Florida Statutes, is repealed.

Reviser's note.—The cited subsection, which relates to payment of estimated tax due no later than Sunday, June 30, 2013, by June 28, 2013, expired pursuant to its own terms, effective July 1, 2014.

Section 7. Paragraph (b) of subsection (2) of section 253.01, Florida Statutes, is repealed.

Reviser's note.—The cited paragraph, which relates to transfer of moneys, for the 2013-2014 fiscal year only, from the Internal Improvement Trust Fund to the Save Our Everglades Trust Fund for Everglades restoration pursuant to s. 216.181(12), expired pursuant to its own terms, effective July 1, 2014.

Section 8. Paragraph (f) of subsection (4) of section 288.106, Florida Statutes, is repealed.

Reviser's note.—The cited paragraph, which permits reduction of local financial support requirements of s. 288.106 by one-half for a qualified

target industry business located in one of a specified list of counties under certain circumstances, expired pursuant to its own terms, effective June 30, 2014.

Section 9. Paragraph (n) of subsection (1) of section 339.08, Florida Statutes, is repealed.

Reviser's note.—The cited paragraph, which relates to expenditure of funds to pay administrative expenses incurred in accordance with applicable laws by the multicounty transportation authority created under chapter 343 where jurisdiction for the authority includes a portion of the State Highway System and the expenses are in furtherance of the provisions of chapter 2012-174, Laws of Florida, to provide a financial analysis of the cost savings to be achieved by the consolidation of transit authorities within the region, expired pursuant to its own terms, effective July 1, 2014.

Section 10. Paragraph (a) of subsection (4) of section 339.135, Florida Statutes, is amended to read:

339.135 Work program; legislative budget request; definitions; preparation, adoption, execution, and amendment.—

(4) FUNDING AND DEVELOPING A TENTATIVE WORK PROGRAM.

(a)1. To assure that no district or county is penalized for local efforts to improve the State Highway System, the department shall, for the purpose of developing a tentative work program, allocate funds for new construction to the districts, except for the turnpike enterprise, based on equal parts of population and motor fuel tax collections. Funds for resurfacing, bridge repair and rehabilitation, bridge fender system construction or repair, public transit projects except public transit block grants as provided in s. 341.052, and other programs with quantitative needs assessments shall be allocated based on the results of these assessments. The department may not transfer any funds allocated to a district under this paragraph to any other district except as provided in subsection (7). Funds for public transit block grants shall be allocated to the districts pursuant to s. 341.052. Funds for the intercity bus program provided for under s. 5311(f) of the federal nonurbanized area formula program shall be administered and allocated directly to eligible bus carriers as defined in s. 341.031(12) at the state level rather than the district. In order to provide state funding to support the intercity bus program provided for under provisions of the federal 5311(f) program, the department shall allocate an amount equal to the federal share of the 5311(f) program from amounts calculated pursuant to s. 206.46(3).

2. Notwithstanding the provisions of subparagraph 1., the department shall allocate at least 50 percent of any new discretionary highway capacity funds to the Florida Strategic Intermodal System created pursuant to s. 339.61. Any remaining new discretionary highway capacity funds shall be allocated to the districts for new construction as provided in subparagraph 1.

For the purposes of this subparagraph, the term "new discretionary highway capacity funds" means any funds available to the department above the prior year funding level for capacity improvements, which the department has the discretion to allocate to highway projects.

~~3. Notwithstanding subparagraphs 1. and 2. and ss. 206.46(3) and 334.044(26), and for fiscal years 2009-2010 through 2013-2014 only, the department shall annually allocate up to $15 million of the first proceeds of the increased revenues estimated by the November 2009 Revenue Estimating Conference to be deposited into the State Transportation Trust Fund to provide for the portion of the transfer of funds included in s. 343.58(4)(a)1.a. or 2.a., as applicable. The transfer of funds included in s. 343.58(4) shall not negatively impact projects included in fiscal years 2009-2010 through 2013-2014 of the work program as of July 1, 2009, as amended pursuant to subsection (7). This subparagraph expires July 1, 2014.~~

Reviser's note.—Amended to delete subparagraph (4)(a)3., which expired pursuant to its own terms, effective July 1, 2014.

Section 11. Section 381.0407, Florida Statutes, is repealed.

Reviser's note.—The cited section, the Managed Care and Publicly Funded Primary Care Program Coordination Act, was repealed by s. 51, ch. 2012-184, effective October 1, 2014. Since the section was not repealed by a "current session" of the Legislature, it may be omitted from the 2015 Florida Statutes only through a reviser's bill duly enacted by the Legislature. See s. 11.242(5)(b) and (i).

Section 12. Paragraph (f) of subsection (1) of section 403.709, Florida Statutes, is repealed.

Reviser's note.—The cited paragraph, which relates to transfer of moneys, for the 2013-2014 fiscal year only, from the Solid Waste Management Trust Fund to the Save Our Everglades Trust Fund for Everglades restoration pursuant to s. 216.181(12), expired pursuant to its own terms, effective July 1, 2014.

Section 13. Subsection (10) of section 409.911, Florida Statutes, is repealed.

Reviser's note.—The cited subsection, which relates to the Medicaid Low-Income Pool Council, expired pursuant to its own terms, effective October 1, 2014.

Section 14. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for

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

~~(1) The agency shall work with the Department of Children and Families to ensure access of children and families in the child protection system to needed and appropriate mental health and substance abuse services. This subsection expires October 1, 2014.~~

~~(2)~~ The agency may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920. This subsection expires October 1, 2016.

~~(3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. This subsection expires October 1, 2014.~~

(2)~~(4)~~ The agency may contract with~~:~~

~~(a) An entity that provides no prepaid health care services other than Medicaid services under contract with the agency and which is owned and operated by a county, county health department, or county-owned and operated hospital to provide health care services on a prepaid or fixed-sum basis to recipients, which entity may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services entities must be licensed under parts I and III of chapter 641. An entity recognized under this paragraph which demonstrates to the satisfaction of the Office of Insurance Regulation of the Financial Services Commission that it is backed by the full faith and credit of the county in which it is located may be exempted from s. 641.225. This paragraph expires October 1, 2014.~~

~~(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c) or paragraph (d), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Families shall approve provisions of procurements related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 5., and except in counties where the Medicaid managed care pilot program is authorized~~

~~pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations and capitated provider service networks, to be expended for the provision of behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.~~

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

~~2. Except as provided in subparagraph 5., the agency and the Department of Children and Families shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization, a provider service network authorized under paragraph (d), or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid~~

~~managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations are eligible to compete. Managed care plans contracting with the agency under subsection (3) or paragraph (d) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts must be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.~~

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

~~4. Traditional community mental health providers under contract with the Department of Children and Families pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Families in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.~~

~~5. All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, which are open for child welfare services in the statewide automated child welfare information system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies through a single agency or formal agreements among several agencies. The agency shall work with the specialty plan to develop clinically effective, evidence-based alternatives as a downward substitution for the statewide inpatient psychiatric program and similar residential care and institutional services. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize~~

~~state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Families. The agency may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the statewide automated child welfare information system and who reside in AHCA area 10 shall be enrolled in a capitated provider service network or other capitated managed care plan, which, in coordination with available community-based care providers specified in s. 409.987, shall provide sufficient medical, developmental, and behavioral health services to meet the needs of these children.~~

~~Effective July 1, 2012, in order to ensure continuity of care, the agency is authorized to extend or modify current contracts based on current service areas or on a regional basis, as determined appropriate by the agency, with comprehensive behavioral health care providers as described in this paragraph during the period prior to its expiration. This paragraph expires October 1, 2014.~~

~~(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. A federally qualified health center or an entity that is owned by one or more federally qualified health centers and is reimbursed by the agency on a prepaid basis is exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet the appropriate requirements governing financial reserve, quality assurance, and patients' rights established by the agency. This paragraph expires October 1, 2014.~~

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

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

~~3. Medicaid recipients assigned to a provider service network shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. This subparagraph expires October 1, 2014.~~

(b)~~4.~~ A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, ~~including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211,~~ which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

~~(c) An entity that provides only comprehensive behavioral health care services to certain Medicaid recipients through an administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services. This paragraph expires October 1, 2014.~~

~~(f) An entity authorized in s. 430.205 to contract with the agency and the Department of Elderly Affairs to provide health care and social services on a prepaid or fixed-sum basis to elderly recipients. Such prepaid health care services entities are exempt from the provisions of part I of chapter 641 for the first 3 years of operation. An entity recognized under this paragraph that demonstrates to the satisfaction of the Office of Insurance Regulation that it is backed by the full faith and credit of one or more counties in which it operates may be exempted from s. 641.225. This paragraph expires October 1, 2013.~~

~~(g) A Children's Medical Services Network, as defined in s. 391.021. This paragraph expires October 1, 2014.~~

~~(5) The agency may contract with any public or private entity otherwise authorized by this section on a prepaid or fixed-sum basis for the provision of health care services to recipients. An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:~~

~~(a) Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;~~

~~(b) Ensures that services meet the standards set by the agency for quality, appropriateness, and timeliness;~~

~~(c) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;~~

~~(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;~~

~~(e) Furnishes evidence satisfactory to the agency of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;~~

~~(f) Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency; and~~

~~(g) Provides organizational, operational, financial, and other information required by the agency.~~

~~This subsection expires October 1, 2014.~~

~~(6) The agency may contract on a prepaid or fixed-sum basis with any health insurer that:~~

~~(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the agency;~~

~~(b) Assumes the underwriting risk; and~~

~~(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Office of Insurance Regulation.~~

~~This subsection expires October 1, 2014.~~

~~(7) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123,~~

~~409.9128, and 627.6472, and other applicable provisions of law. This subsection expires October 1, 2014.~~

~~(8) The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization. This subsection expires October 1, 2014.~~

~~(9) The agency shall not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:~~

~~(a) Fraud;~~

~~(b) Violation of federal or state antitrust statutes, including those proscribing price fixing between competitors and the allocation of customers among competitors;~~

~~(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or~~

~~(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.~~

~~This subsection expires October 1, 2014.~~

(3)~~(10)~~ The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services. Prior to seeking legislative approval of such a waiver as authorized by this subsection, the agency shall provide notice and an opportunity for public comment. Notice shall be provided to all persons who have made requests of the agency for advance notice and shall be published in the Florida Administrative Register not less than 28 days prior to the intended action. This subsection expires October 1, 2016.

~~(11) The agency shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse. This subsection expires October 1, 2014.~~

~~(12) The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area. This subsection expires October 1, 2014.~~

~~(13) The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use of services and to eliminate services that are medically unnecessary. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services. Providers that demonstrate a pattern of submitting claims for medically unnecessary services shall be referred to the Medicaid program integrity unit for investigation. In its annual report, required in s. 409.913, the agency shall report on its efforts to control overutilization as described in this subsection. This subsection expires October 1, 2014.~~

~~(14)(a) The agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) nursing facility preadmission screening program to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. The CARES program shall also ensure that individuals participating in Medicaid home and community-based waiver programs meet criteria for those programs, consistent with approved federal waivers.~~

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

~~(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the individual requires nursing facility care and that the individual cannot be safely served in community-~~

~~based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program. For individuals whose nursing home stay is initially funded by Medicare and Medicare coverage is being terminated for lack of progress towards rehabilitation, CARES staff shall consult with the person making the determination of progress toward rehabilitation to ensure that the recipient is not being inappropriately disqualified from Medicare coverage. If, in their professional judgment, CARES staff believes that a Medicare beneficiary is still making progress toward rehabilitation, they may assist the Medicare beneficiary with an appeal of the disqualification from Medicare coverage. The use of CARES teams to review Medicare denials for coverage under this section is authorized only if it is determined that such reviews qualify for federal matching funds through Medicaid. The agency shall seek or amend federal waivers as necessary to implement this section.~~

~~(d) For the purpose of initiating immediate prescreening and diversion assistance for individuals residing in nursing homes and in order to make families aware of alternative long-term care resources so that they may choose a more cost-effective setting for long-term placement, CARES staff shall conduct an assessment and review of a sample of individuals whose nursing home stay is expected to exceed 20 days, regardless of the initial funding source for the nursing home placement. CARES staff shall provide counseling and referral services to these individuals regarding choosing appropriate long-term care alternatives. This paragraph does not apply to continuing care facilities licensed under chapter 651 or to retirement communities that provide a combination of nursing home, independent living, and other long-term care services.~~

~~(e) By January 15 of each year, the agency shall submit a report to the Legislature describing the operations of the CARES program. The report must describe:~~

~~1. Rate of diversion to community alternative programs;~~

~~2. CARES program staffing needs to achieve additional diversions;~~

~~3. Reasons the program is unable to place individuals in less restrictive settings when such individuals desired such services and could have been served in such settings;~~

~~4. Barriers to appropriate placement, including barriers due to policies or operations of other agencies or state-funded programs; and~~

~~5. Statutory changes necessary to ensure that individuals in need of long-term care services receive care in the least restrictive environment.~~

~~(f) The Department of Elderly Affairs shall track individuals over time who are assessed under the CARES program and who are diverted from nursing home placement. By January 15 of each year, the department shall~~

~~submit to the Legislature a longitudinal study of the individuals who are diverted from nursing home placement. The study must include:~~

~~1. The demographic characteristics of the individuals assessed and diverted from nursing home placement, including, but not limited to, age, race, gender, frailty, caregiver status, living arrangements, and geographic location;~~

~~2. A summary of community services provided to individuals for 1 year after assessment and diversion;~~

~~3. A summary of inpatient hospital admissions for individuals who have been diverted; and~~

~~4. A summary of the length of time between diversion and subsequent entry into a nursing home or death.~~

~~This subsection expires October 1, 2013.~~

~~(15)(a) The agency shall identify health care utilization and price patterns within the Medicaid program which are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate. Such methods may include disease management initiatives, an integrated and systematic approach for managing the health care needs of recipients who are at risk of or diagnosed with a specific disease by using best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools and resources to reduce overall costs and improve measurable outcomes.~~

~~(b) The responsibility of the agency under this subsection includes the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.~~

~~1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with the Department of Health and a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459, and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice~~

~~pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization or may be terminated from all participation in the Medicaid program.~~

~~2. The agency shall also develop educational interventions designed to promote the proper use of medications by providers and beneficiaries.~~

~~3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries inappropriately using their benefits, and other steps that eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.~~

~~4. The agency may contract with an entity in the state to provide Medicaid providers with electronic access to Medicaid prescription refill data and information relating to the Medicaid preferred drug list. The initiative shall be designed to enhance the agency's efforts to reduce fraud, abuse, and errors in the prescription drug benefit program and to otherwise further the intent of this paragraph.~~

~~5. The agency shall contract with an entity to design a database of clinical utilization information or electronic medical records for Medicaid providers. The database must be web-based and allow providers to review on a real-time basis the utilization of Medicaid services, including, but not limited to, physician office visits, inpatient and outpatient hospitalizations, laboratory and pathology services, radiological and other imaging services, dental care, and patterns of dispensing prescription drugs in order to coordinate care and identify potential fraud and abuse.~~

~~6. The agency may apply for any federal waivers needed to administer this paragraph.~~

~~This subsection expires October 1, 2014.~~

~~(16) An entity contracting on a prepaid or fixed-sum basis shall meet the surplus requirements of s. 641.225. If an entity's surplus falls below an amount equal to the surplus requirements of s. 641.225, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and may not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:~~

~~(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or~~

~~(b) Where the entity's performance and obligations are guaranteed in writing by a guaranteeing organization which:~~

~~1. Has been in operation for at least 5 years and has assets in excess of $50 million; or~~

~~2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract, until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.~~

~~This subsection expires October 1, 2014.~~

(4)~~(17)~~(a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in this state. The entity shall deposit into that account 5 percent of the capitation payments made by the agency each month until a maximum total of 2 percent of the total current contract amount is reached. The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the entity and two representatives of the agency. If the agency finds that the entity is insolvent, the agency may draw upon the account solely with the two authorized signatures of representatives of the agency, and the funds may be disbursed to meet financial obligations incurred by the entity under the prepaid contract. If the contract is terminated, expired, or not continued, the account balance must be released by the agency to the entity upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

(b) The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance that will protect enrollees if the entity becomes unable to meet its obligations.

~~(18) An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall reimburse any hospital or physician that is outside the entity's authorized geographic service area as specified in its contract with the agency, and that provides services authorized by the entity to its members, at a rate negotiated with the hospital or physician for the provision of services or according to the lesser of the following:~~

~~(a) The usual and customary charges made to the general public by the hospital or physician; or~~

~~(b) The Florida Medicaid reimbursement rate established for the hospital or physician.~~

~~This subsection expires October 1, 2014.~~

~~(19) When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Office of Insurance Regulation pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger~~

~~or acquisition if the contractor and the other entity have been in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase. This subsection expires October 1, 2014.~~

(5)~~(20)~~ Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

(a) Practices that are discriminatory, including, but not limited to, attempts to discourage participation on the basis of actual or perceived health status.

(b) Activities that could mislead or confuse recipients, or misrepresent the organization, its marketing representatives, or the agency. Violations of this paragraph include, but are not limited to:

1. False or misleading claims that marketing representatives are employees or representatives of the state or county, or of anyone other than the entity or the organization by whom they are reimbursed.

2. False or misleading claims that the entity is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the entity.

3. False or misleading claims that the state or county recommends that a Medicaid recipient enroll with an entity.

4. Claims that a Medicaid recipient will lose benefits under the Medicaid program, or any other health or welfare benefits to which the recipient is legally entitled, if the recipient does not enroll with the entity.

(c) Granting or offering of any monetary or other valuable consideration for enrollment~~, except as authorized by subsection (23)~~.

(d) Door-to-door solicitation of recipients who have not contacted the entity or who have not invited the entity to make a presentation.

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

(6)~~(21)~~ The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of this section or the contract with the agency, the agency may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

~~(22) A health maintenance organization or a person or entity exempt from chapter 641 that is under contract with the agency for the provision of health care services to Medicaid recipients may not use or distribute marketing materials used to solicit Medicaid recipients, unless such materials have been approved by the agency. The provisions of this subsection do not apply to general advertising and marketing materials used by a health maintenance organization to solicit both non-Medicaid subscribers and Medicaid recipients. This subsection expires October 1, 2014.~~

~~(23) Upon approval by the agency, health maintenance organizations and persons or entities exempt from chapter 641 that are under contract with the agency for the provision of health care services to Medicaid recipients may be permitted within the capitation rate to provide additional health benefits that the agency has found are of high quality, are practicably available, provide reasonable value to the recipient, and are provided at no additional cost to the state. This subsection expires October 1, 2014.~~

~~(24) The agency shall utilize the statewide health maintenance organization complaint hotline for the purpose of investigating and resolving Medicaid and prepaid health plan complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by recipients. This subsection expires October 1, 2014.~~

~~(25) The agency shall require the publication of the health maintenance organization's and the prepaid health plan's consumer services telephone numbers and the "800" telephone number of the statewide health maintenance organization complaint hotline on each Medicaid identification card issued by a health maintenance organization or prepaid health plan contracting with the agency to serve Medicaid recipients and on each subscriber handbook issued to a Medicaid recipient. This subsection expires October 1, 2014.~~

(7)~~(26)~~ The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Centers for Medicare and Medicaid Services ~~Bureau of the Health Care~~

~~Financing Administration~~ as a part of the quality assurance reform initiative. The system shall include, but need not be limited to, the following:

(a) Guidelines for internal quality assurance programs, including standards for:

1. Written quality assurance program descriptions.

2. Responsibilities of the governing body for monitoring, evaluating, and making improvements to care.

3. An active quality assurance committee.

4. Quality assurance program supervision.

5. Requiring the program to have adequate resources to effectively carry out its specified activities.

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

12. Accessibility and availability of medical records, as well as proper recordkeeping and process for record review.

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

16. Coordination of quality assurance activity with other management activity.

17. Delivering care to pregnant women and infants; to elderly and disabled recipients, especially those who are at risk of institutional placement; to persons with developmental disabilities; and to adults who have chronic, high-cost medical conditions.

(b) Guidelines which require the entities to conduct quality-of-care studies which:

1. Target specific conditions and specific health service delivery issues for focused monitoring and evaluation.

2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions and health services delivery issues.

3. Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

(c) Guidelines for external quality review of each contractor which require: focused studies of patterns of care; individual care review in specific situations; and followup activities on previous pattern-of-care study findings and individual-care-review findings. In designing the external quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

1. Delineating the role of the external quality review organization.

2. Length of the external quality review organization contract with the state.

3. Participation of the contracting entities in designing external quality review organization review activities.

4. Potential variation in the type of clinical conditions and health services delivery issues to be studied at each plan.

5. Determining the number of focused pattern-of-care studies to be conducted for each plan.

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

This subsection expires October 1, 2016.

~~(27) In order to ensure that children receive health care services for which an entity has already been compensated, an entity contracting with the agency pursuant to this section shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months. The agency shall develop a method by which the EPSDT screening rate shall be calculated. For any entity which does not achieve the annual 60 percent rate, the entity must submit a corrective action plan for the agency's approval. If the entity does not meet the standard established in the corrective action plan during the specified timeframe, the agency is authorized to impose appropriate contract sanctions. At least annually, the agency shall publicly release the EPSDT Services screening rates of each entity it has contracted with on a prepaid basis to serve Medicaid recipients. This subsection expires October 1, 2014.~~

~~(28) The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (20)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, the term "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but does not include actual enrollment into a managed care plan. An application for enrollment may not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Families, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and may adopt rules to administer such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract. This subsection expires October 1, 2014.~~

~~(29) Any lists of providers made available to Medicaid recipients, MediPass enrollees, or managed care plan enrollees shall be arranged alphabetically showing the provider's name and specialty and, separately, by specialty in alphabetical order. This subsection expires October 1, 2014.~~

~~(30) The agency shall establish an enhanced managed care quality assurance oversight function, to include at least the following components:~~

~~(a) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant utilization of services.~~

~~(b) At least quarterly analysis and followup, including sanctions as appropriate, of quality findings of the Medicaid peer review organization and other external quality assurance programs.~~

~~(c) At least quarterly analysis and followup, including sanctions as appropriate, of the fiscal viability of managed care plans.~~

~~(d) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant satisfaction and disenrollment surveys.~~

~~(e) The agency shall conduct regular and ongoing Medicaid recipient satisfaction surveys.~~

~~The analyses and followup activities conducted by the agency under its enhanced managed care quality assurance oversight function shall not duplicate the activities of accreditation reviewers for entities regulated under part III of chapter 641, but may include a review of the finding of such reviewers. This subsection expires October 1, 2014.~~

~~(31) Each managed care plan that is under contract with the agency to provide health care services to Medicaid recipients shall annually conduct a background check with the Department of Law Enforcement of all persons with ownership interest of 5 percent or more or executive management responsibility for the managed care plan and shall submit to the agency information concerning any such person who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.04. This subsection expires October 1, 2014.~~

~~(32) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs. This subsection expires October 1, 2014.~~

~~(33) The agency and entities that contract with the agency to provide health care services to Medicaid recipients under this section or ss. 409.91211 and 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients. Where feasible, safe, and cost-effective, the agency shall encourage hospitals, emergency medical services providers, and other public and private health care providers to work together in their local communities to enter into agreements or arrangements to ensure access to alternatives to emergency services and care for those Medicaid recipients who need nonemergent care. The agency shall coordinate with hospitals, emergency medical services providers, private health plans, capitated managed care networks as established in s. 409.91211, and other public and private health care providers to implement the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405, and 641.31097 to develop and implement emergency department diversion programs for Medicaid recipients. This subsection expires October 1, 2014.~~

~~(34) All entities providing health care services to Medicaid recipients shall make available, and encourage all pregnant women and mothers with infants to receive, and provide documentation in the medical records to reflect, the following:~~

~~(a) Healthy Start prenatal or infant screening.~~

~~(b) Healthy Start care coordination, when screening or other factors indicate need.~~

~~(c) Healthy Start enhanced services in accordance with the prenatal or infant screening results.~~

~~(d) Immunizations in accordance with recommendations of the Advisory Committee on Immunization Practices of the United States Public Health Service and the American Academy of Pediatrics, as appropriate.~~

~~(e) Counseling and services for family planning to all women and their partners.~~

~~(f) A scheduled postpartum visit for the purpose of voluntary family planning, to include discussion of all methods of contraception, as appropriate.~~

~~(g) Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).~~

~~This subsection expires October 1, 2014.~~

~~(35) Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise. This subsection expires October 1, 2014.~~

~~(36) The agency shall enter into agreements with not-for-profit organizations based in this state for the purpose of providing vision screening. This subsection expires October 1, 2014.~~

(8)~~(37)~~(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer this subparagraph. The agency shall continue to provide

unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lowest of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the

use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage guarantees a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency may contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers to implement this initiative.

8. The agency shall expand home delivery of pharmacy products. The agency may amend the state plan and issue a procurement, as necessary, in order to implement this program. The procurements must include agreements with a pharmacy or pharmacies located in the state to provide mail order delivery services at no cost to the recipients who elect to receive home delivery of pharmacy products. The procurement must focus on serving recipients with chronic diseases for which pharmacy expenditures represent a significant portion of Medicaid pharmacy expenditures or which impact a significant portion of the Medicaid population. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

9. The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.

10.a. The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency may seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Families, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

11. The agency shall implement a Medicaid prescription drug management system.

a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to recipients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

12. The agency may contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

13. The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

15. The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

16. The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

17. The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

(c) The agency shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures.

(9)~~(38)~~ Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times for such periods as the agency may decide; however, all such renewals may not combine to exceed a total period longer than the term of the original contract.

~~(39) The agency shall establish a demonstration project in Miami-Dade County of a long-term-care facility and a psychiatric facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and collocated with licensed facilities providing a continuum of care. These projects are not subject to the provisions of s. 408.036 or s. 408.039. This subsection expires October 1, 2013.~~

~~(40) The agency shall develop and implement a utilization management program for Medicaid-eligible recipients for the management of occupational, physical, respiratory, and speech therapies. The agency shall establish a utilization program that may require prior authorization in order to ensure medically necessary and cost-effective treatments. The program shall be operated in accordance with a federally approved waiver program or state plan amendment. The agency may seek a federal waiver or state plan amendment to implement this program. The agency may also competitively procure these services from an outside vendor on a regional or statewide basis. This subsection expires October 1, 2014.~~

~~(41)(a) The agency shall contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services. This paragraph expires October 1, 2014.~~

~~(b) Notwithstanding paragraph (a) and for the 2012-2013 fiscal year only, the agency is authorized to provide a Medicaid prepaid dental health program in Miami-Dade County. For all other counties, the agency may not limit dental services to prepaid plans and must allow qualified dental providers to provide dental services under Medicaid on a fee-for-service reimbursement methodology. The agency may seek any necessary revisions or amendments to the state plan or federal waivers in order to implement this paragraph. The agency shall terminate existing contracts as needed to implement this paragraph. This paragraph expires July 1, 2013.~~

~~(42) The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(f), whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which may be adjusted for health status. The agency shall conduct actuarially sound adjustments for health status in order to ensure such cost-effectiveness and shall annually publish the results on its Internet website. Contracts established pursuant to this subsection which are not cost-effective may not be renewed. This subsection expires October 1, 2014.~~

~~(43) Subject to the availability of funds, the agency shall mandate a recipient's participation in a provider lock-in program, when appropriate, if a recipient is found by the agency to have used Medicaid goods or services at a frequency or amount not medically necessary, limiting the receipt of goods or services to medically necessary providers after the 21-day appeal process has ended, for a period of not less than 1 year. The lock-in programs shall include, but are not limited to, pharmacies, medical doctors, and infusion clinics. The limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department. The agency shall seek any federal waivers necessary to implement this subsection. The agency shall adopt any rules necessary to comply with or administer this subsection. This subsection expires October 1, 2014.~~

(10)~~(44)~~ The agency shall seek a federal waiver for permission to terminate the eligibility of a Medicaid recipient who has been found to have committed fraud, through judicial or administrative determination, two times in a period of 5 years.

(11)~~(45)~~(a) A provider is not entitled to enrollment in the Medicaid provider network. The agency may implement a Medicaid fee-for-service provider network controls, including, but not limited to, competitive procurement and provider credentialing. If a credentialing process is used,

the agency may limit its provider network based upon the following considerations: beneficiary access to care, provider availability, provider quality standards and quality assurance processes, cultural competency, demographic characteristics of beneficiaries, practice standards, service wait times, provider turnover, provider licensure and accreditation history, program integrity history, peer review, Medicaid policy and billing compliance records, clinical and medical record audit findings, and such other areas that are considered necessary by the agency to ensure the integrity of the program.

(b) The agency shall limit its network of durable medical equipment and medical supply providers. For dates of service after January 1, 2009, the agency shall limit payment for durable medical equipment and supplies to providers that meet all the requirements of this paragraph.

1. Providers must be accredited by a Centers for Medicare and Medicaid Services deemed accreditation organization for suppliers of durable medical equipment, prosthetics, orthotics, and supplies. The provider must maintain accreditation and is subject to unannounced reviews by the accrediting organization.

2. Providers must provide the services or supplies directly to the Medicaid recipient or caregiver at the provider location or recipient's residence or send the supplies directly to the recipient's residence with receipt of mailed delivery. Subcontracting or consignment of the service or supply to a third party is prohibited.

3. Notwithstanding subparagraph 2., a durable medical equipment provider may store nebulizers at a physician's office for the purpose of having the physician's staff issue the equipment if it meets all of the following conditions:

a. The physician must document the medical necessity and need to prevent further deterioration of the patient's respiratory status by the timely delivery of the nebulizer in the physician's office.

b. The durable medical equipment provider must have written documentation of the competency and training by a Florida-licensed registered respiratory therapist of any durable medical equipment staff who participate in the training of physician office staff for the use of nebulizers, including cleaning, warranty, and special needs of patients.

c. The physician's office must have documented the training and competency of any staff member who initiates the delivery of nebulizers to patients. The durable medical equipment provider must maintain copies of all physician office training.

d. The physician's office must maintain inventory records of stored nebulizers, including documentation of the durable medical equipment provider source.

e. A physician contracted with a Medicaid durable medical equipment provider may not have a financial relationship with that provider or receive any financial gain from the delivery of nebulizers to patients.

4. Providers must have a physical business location and a functional landline business phone. The location must be within the state or not more than 50 miles from the Florida state line. The agency may make exceptions for providers of durable medical equipment or supplies not otherwise available from other enrolled providers located within the state.

5. Physical business locations must be clearly identified as a business that furnishes durable medical equipment or medical supplies by signage that can be read from 20 feet away. The location must be readily accessible to the public during normal, posted business hours and must operate at least 5 hours per day and at least 5 days per week, with the exception of scheduled and posted holidays. The location may not be located within or at the same numbered street address as another enrolled Medicaid durable medical equipment or medical supply provider or as an enrolled Medicaid pharmacy that is also enrolled as a durable medical equipment provider. A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider is exempt from this paragraph.

6. Providers must maintain a stock of durable medical equipment and medical supplies on site that is readily available to meet the needs of the durable medical equipment business location's customers.

7. Providers must provide a surety bond of $50,000 for each provider location, up to a maximum of 5 bonds statewide or an aggregate bond of $250,000 statewide, as identified by Federal Employer Identification Number. Providers who post a statewide or an aggregate bond must identify all of their locations in any Medicaid durable medical equipment and medical supply provider enrollment application or bond renewal. Each provider location's surety bond must be renewed annually and the provider must submit proof of renewal even if the original bond is a continuous bond. A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider is exempt from the provisions in this paragraph.

8. Providers must obtain a level 2 background screening, in accordance with chapter 435 and s. 408.809, for each provider employee in direct contact with or providing direct services to recipients of durable medical equipment and medical supplies in their homes. This requirement includes, but is not limited to, repair and service technicians, fitters, and delivery staff. The provider shall pay for the cost of the background screening.

9. The following providers are exempt from subparagraphs 1. and 7.:

a. Durable medical equipment providers owned and operated by a government entity.

b. Durable medical equipment providers that are operating within a pharmacy that is currently enrolled as a Medicaid pharmacy provider.

c. Active, Medicaid-enrolled orthopedic physician groups, primarily owned by physicians, which provide only orthotic and prosthetic devices.

~~(46) The agency shall contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.~~

~~(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules.~~

~~(b) The agency shall reimburse each minority physician network as a fee-for-service provider, including the case management fee for primary care, if any, or as a capitated rate provider for Medicaid services. Any savings shall be shared with the minority physician networks pursuant to the contract.~~

~~(c) For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall annually publish the audit results on its Internet website. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.~~

~~(d) The agency may apply for any federal waivers needed to implement this subsection.~~

~~This subsection expires October 1, 2014.~~

(12)~~(47)~~ To the extent permitted by federal law and as allowed under s. 409.906, the agency shall provide reimbursement for emergency mental health care services for Medicaid recipients in crisis stabilization facilities licensed under s. 394.875 as long as those services are less expensive than the same services provided in a hospital setting.

(13)~~(48)~~ The agency shall work with the Agency for Persons with Disabilities to develop a home and community-based waiver to serve children and adults who are diagnosed with familial dysautonomia or Riley-Day syndrome caused by a mutation of the IKBKAP gene on chromosome 9. The agency shall seek federal waiver approval and implement the approved

waiver subject to the availability of funds and any limitations provided in the General Appropriations Act. The agency may adopt rules to implement this waiver program.

(14)~~(49)~~ The agency shall implement a program of all-inclusive care for children. The program of all-inclusive care for children shall be established to provide in-home hospice-like support services to children diagnosed with a life-threatening illness and enrolled in the Children's Medical Services network to reduce hospitalizations as appropriate. The agency, in consultation with the Department of Health, may implement the program of all-inclusive care for children after obtaining approval from the Centers for Medicare and Medicaid Services.

(15)~~(50)~~ Before seeking an amendment to the state plan for purposes of implementing programs authorized by the Deficit Reduction Act of 2005, the agency shall notify the Legislature.

(16)~~(51)~~ The agency may not pay for psychotropic medication prescribed for a child in the Medicaid program without the express and informed consent of the child's parent or legal guardian. The physician shall document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription. The express and informed consent or court authorization for a prescription of psychotropic medication for a child in the custody of the Department of Children and Families shall be obtained pursuant to s. 39.407.

Reviser's note.—Amended to conform to the repeals of numerous subunits pursuant to their own terms, effective at various dates in 2013 and 2014. Material in existing s. 409.912(4)(d)4. referencing s. 409.91211 was deleted to conform to the repeal of that section effective October 1, 2014, by s. 20, ch. 2011-135, Laws of Florida, and confirmation of that repeal by this reviser's bill. The reference in subsection (26), redesignated here as subsection (7), to the Medicaid Bureau of the Health Care Financing Administration was redesignated as the Centers for Medicare and Medicaid Services to conform to the renaming of the federal agency.

Section 15. Section 409.91211, Florida Statutes, is repealed.

Reviser's note.—The cited section, which relates to the Medicaid managed care pilot program, was repealed by s. 20, ch. 2011-135, Laws of Florida, effective October 1, 2014. Since the section was not repealed by a "current session" of the Legislature, it may be omitted from the 2015 Florida Statutes only through a reviser's bill duly enacted by the Legislature. See s. 11.242(5)(b) and (i).

Section 16. Section 409.9122, Florida Statutes, is amended to read:

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

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

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

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

~~2. If the recipient chooses to enroll in a managed care plan, the agency has determined that the managed care plan provides specific programs and services which address the special health needs of the recipient; and~~

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

~~School districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.~~

~~(b) A Medicaid recipient may not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (4)(a) and (b), respectively.~~

~~(c) Medicaid recipients shall have a choice of managed care plans or MediPass. The Agency for Health Care Administration, the Department of Health, the Department of Children and Families, and the Department of Elderly Affairs shall cooperate to ensure that each Medicaid recipient receives clear and easily understandable information that meets the following requirements:~~

~~1. Explains the concept of managed care, including MediPass.~~

~~2. Provides information on the comparative performance of managed care plans and MediPass in the areas of quality, credentialing, preventive health programs, network size and availability, and patient satisfaction.~~

~~3. Explains where additional information on each managed care plan and MediPass in the recipient's area can be obtained.~~

~~4. Explains that recipients have the right to choose their managed care coverage at the time they first enroll in Medicaid and again at regular intervals set by the agency. However, if a recipient does not choose a managed care plan or MediPass, the agency will assign the recipient to a managed care plan or MediPass according to the criteria specified in this section.~~

~~5. Explains the recipient's right to complain, file a grievance, or change managed care plans or MediPass providers if the recipient is not satisfied with the managed care plan or MediPass.~~

~~(d) The agency shall develop a mechanism for providing information to Medicaid recipients for the purpose of making a managed care plan or MediPass selection. Examples of such mechanisms may include, but not be limited to, interactive information systems, mailings, and mass marketing materials. Managed care plans and MediPass providers are prohibited from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans or MediPass providers.~~

~~(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice shall be assigned in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).~~

~~(f) If a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass to the Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be operated economically. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:~~

~~1. A managed care plan has sufficient network capacity to meet the need of members.~~

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

~~3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.~~

~~4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.~~

~~(g) When more than one managed care plan or MediPass provider meets the criteria specified in paragraph (f), the agency shall make recipient assignments consecutively by family unit.~~

~~(h) The agency may not engage in practices that are designed to favor one managed care plan over another or that are designed to influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.~~

~~(i) After a recipient has made his or her selection or has been enrolled in a managed care plan or MediPass, the recipient shall have 90 days to exercise the opportunity to voluntarily disenroll and select another managed care plan or MediPass. After 90 days, no further changes may be made except for good cause. Good cause includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency shall develop criteria for good cause disenrollment for chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through the MediPass program. The agency must make a determination as to whether cause exists. However, the agency may require a recipient to use the managed care plan's or MediPass grievance process prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when utilized, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If the managed care plan or MediPass, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.~~

~~(j) The agency shall apply for a federal waiver from the Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an open enrollment period. After 12 months' enrollment, a recipient may select another managed care plan or MediPass provider. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the managed care plan or MediPass program during the 12-month period.~~

~~(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans~~

~~accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:~~

~~1. A managed care plan has sufficient network capacity to meet the need of members.~~

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

~~3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.~~

~~4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.~~

~~5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.~~

~~(l) Notwithstanding chapter 287, the agency may renew cost-effective contracts for choice counseling services once or more for such periods as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.~~

~~This subsection expires October 1, 2014.~~

~~(3)~~ Notwithstanding s. 409.961, if a Medicaid recipient is diagnosed with HIV/AIDS, the agency shall assign the recipient to a managed care plan that is a health maintenance organization authorized under chapter 641, that is under contract with the agency as an HIV/AIDS specialty plan as of January 1, 2013, and that offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS. This subsection applies to recipients who are subject to mandatory managed care enrollment and have failed to choose a managed care option.

~~(4)(a) The agency shall establish quality-of-care standards for managed care plans. These standards shall be based upon, but are not limited to:~~

~~1. Compliance with the accreditation requirements as provided in s. 641.512.~~

~~2. Compliance with Early and Periodic Screening, Diagnosis, and Treatment screening requirements.~~

~~3. The percentage of voluntary disenrollments.~~

~~4. Immunization rates.~~

~~5. Standards of the National Committee for Quality Assurance and other approved accrediting bodies.~~

~~6. Recommendations of other authoritative bodies.~~

~~7. Specific requirements of the Medicaid program, or standards designed to specifically assist the unique needs of Medicaid recipients.~~

~~8. Compliance with the health quality improvement system as established by the agency, which incorporates standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as part of the quality assurance reform initiative.~~

~~(b) For the MediPass program, the agency shall establish standards which are based upon, but are not limited to:~~

~~1. Quality-of-care standards which are comparable to those required of managed care plans.~~

~~2. Credentialing standards for MediPass providers.~~

~~3. Compliance with Early and Periodic Screening, Diagnosis, and Treatment screening requirements.~~

~~4. Immunization rates.~~

~~5. Specific requirements of the Medicaid program, or standards designed to specifically assist the unique needs of Medicaid recipients.~~

~~This subsection expires October 1, 2014.~~

~~(5)(a) Each female recipient may select as her primary care provider an obstetrician/gynecologist who has agreed to participate as a MediPass primary care case manager.~~

~~(b) The agency shall establish a complaints and grievance process to assist Medicaid recipients enrolled in the MediPass program to resolve complaints and grievances. The agency shall investigate reports of quality-of-care grievances which remain unresolved to the satisfaction of the enrollee.~~

~~This subsection expires October 1, 2014.~~

~~(6)(a) The agency shall work cooperatively with the Social Security Administration to identify beneficiaries who are jointly eligible for Medicare and Medicaid and shall develop cooperative programs to encourage these beneficiaries to enroll in a Medicare participating health maintenance organization or prepaid health plans.~~

~~(b) The agency shall work cooperatively with the Department of Elderly Affairs to assess the potential cost-effectiveness of providing MediPass to beneficiaries who are jointly eligible for Medicare and Medicaid on a voluntary choice basis. If the agency determines that enrollment of these beneficiaries in MediPass has the potential for being cost-effective for the state, the agency shall offer MediPass to these beneficiaries on a voluntary choice basis in the counties where MediPass operates.~~

~~This subsection expires October 1, 2014.~~

~~(7) MediPass enrolled recipients may receive up to 10 visits of reimbursable services by participating Medicaid physicians licensed under chapter 460 and up to four visits of reimbursable services by participating Medicaid physicians licensed under chapter 461. Any further visits must be by prior authorization by the MediPass primary care provider. However, nothing in this subsection may be construed to increase the total number of visits or the total amount of dollars per year per person under current Medicaid rules, unless otherwise provided for in the General Appropriations Act. This subsection expires October 1, 2014.~~

~~(8)(a) The agency shall develop and implement a comprehensive plan to ensure that recipients are adequately informed of their choices and rights under all Medicaid managed care programs and that Medicaid managed care programs meet acceptable standards of quality in patient care, patient satisfaction, and financial solvency.~~

~~(b) The agency shall provide adequate means for informing patients of their choice and rights under a managed care plan at the time of eligibility determination.~~

~~(c) The agency shall require managed care plans and MediPass providers to demonstrate and document plans and activities, as defined by rule, including outreach and followup, undertaken to ensure that Medicaid recipients receive the health care service to which they are entitled.~~

~~This subsection expires October 1, 2014.~~

~~(9) The agency shall consult with Medicaid consumers and their representatives on an ongoing basis regarding measurements of patient satisfaction, procedures for resolving patient grievances, standards for ensuring quality of care, mechanisms for providing patient access to services, and policies affecting patient care. This subsection expires October 1, 2014.~~

~~(10) The agency may extend eligibility for Medicaid recipients enrolled in licensed and accredited health maintenance organizations for the duration of the enrollment period or for 6 months, whichever is earlier, provided the agency certifies that such an offer will not increase state expenditures. This subsection expires October 1, 2013.~~

~~(11) A managed care plan that has a Medicaid contract shall at least annually review each primary care physician's active patient load and shall ensure that additional Medicaid recipients are not assigned to physicians who have a total active patient load of more than 3,000 patients. As used in this subsection, the term "active patient" means a patient who is seen by the same primary care physician, or by a physician assistant or advanced registered nurse practitioner under the supervision of the primary care physician, at least three times within a calendar year. Each primary care physician shall annually certify to the managed care plan whether or not his or her patient load exceeds the limits established under this subsection and the managed care plan shall accept such certification on face value as compliance with this subsection. The agency shall accept the managed care plan's representations that it is in compliance with this subsection based on the certification of its primary care physicians, unless the agency has an objective indication that access to primary care is being compromised, such as receiving complaints or grievances relating to access to care. If the agency determines that an objective indication exists that access to primary care is being compromised, it may verify the patient load certifications submitted by the managed care plan's primary care physicians and that the managed care plan is not assigning Medicaid recipients to primary care physicians who have an active patient load of more than 3,000 patients. This subsection expires October 1, 2014.~~

~~(12) Effective July 1, 2003, the agency shall adjust the enrollee assignment process of Medicaid managed prepaid health plans for those Medicaid managed prepaid plans operating in Miami-Dade County which have executed a contract with the agency for a minimum of 8 consecutive years in order for the Medicaid managed prepaid plan to maintain a minimum enrollment level of 15,000 members per month. When assigning enrollees pursuant to this subsection, the agency shall give priority to providers that initially qualified under this subsection until such providers reach and maintain an enrollment level of 15,000 members per month. A prepaid health plan that has a statewide Medicaid enrollment of 25,000 or more members is not eligible for enrollee assignments under this subsection. This subsection expires October 1, 2014.~~

(2)~~(13)~~ The agency shall include in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate any special payments, including, but not limited to, upper payment limit or disproportionate share hospital payments, made to qualifying hospitals through the fee-for-service program. The agency may seek federal waiver approval or state plan amendment as needed to implement this adjustment.

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

(4)~~(15)~~ The agency shall maintain and operate the Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Florida Medicaid recipients enrolled in prepaid managed care plans.

(a) Prepaid managed care plans shall submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid managed care plans must certify that the data reported is accurate and complete.

(b) The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

(5)~~(16)~~ The agency may establish a per-member, per-month payment for Medicare Advantage Special Needs members that are also eligible for Medicaid as a mechanism for meeting the state's cost-sharing obligation. The agency may also develop a per-member, per-month payment only for Medicaid-covered services for which the state is responsible. The agency shall develop a mechanism to ensure that such per-member, per-month payment enhances the value to the state and enrolled members by limiting cost sharing, enhances the scope of Medicare supplemental benefits that are equal to or greater than Medicaid coverage for select services, and improves care coordination.

(6)~~(17)~~ The agency shall establish, and managed care plans shall use, a uniform method of accounting for and reporting medical and nonmedical costs.

(a) Managed care plans shall submit financial data electronically in a format that complies with the uniform accounting procedures established by the agency. Managed care plans must certify that the data reported is accurate and complete.

(b) The agency is responsible for validating the financial data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of data that adjusts for differences in characteristics of plan enrollees to allow comparison among plans and against expected levels of expenditures. The analysis shall be used to identify possible cases of overspending on administrative costs or underspending on medical services.

(7)~~(18)~~ The agency shall establish and maintain an information system to make encounter data, financial data, and other measures of plan performance available to the public and any interested party.

(a) Information submitted by the managed care plans shall be available online as well as in other formats.

(b) Periodic agency reports shall be published that include summary as well as plan specific measures of financial performance and service utilization.

(c) Any release of the financial and encounter data submitted by managed care plans shall ensure the confidentiality of personal health information.

(8)~~(19)~~ The agency may, on a case-by-case basis, exempt a recipient from mandatory enrollment in a managed care plan when the recipient has a unique, time-limited disease or condition-related circumstance and managed care enrollment will interfere with ongoing care because the recipient's provider does not participate in the managed care plans available in the recipient's area.

~~(20) The agency shall contract with a single provider service network to function as a managing entity for the MediPass program in all counties with fewer than two prepaid plans. The contractor shall be responsible for implementing preauthorization procedures, case management programs, and utilization management initiatives in order to improve care coordination and patient outcomes while reducing costs. The contractor may earn an administrative fee if the fee is less than any savings as determined by the reconciliation process under s. 409.912(4)(d)1. This subsection expires October 1, 2014, or upon full implementation of the managed medical assistance program, whichever is sooner.~~

~~(21) Subject to federal approval, the agency shall contract with a single provider service network to function as a third-party administrator and managing entity for the Medically Needy program in all counties. The contractor shall provide care coordination and utilization management in order to achieve more cost-effective services for Medically Needy enrollees.~~

~~To facilitate the care management functions of the provider service network, enrollment in the network shall be for a continuous 6-month period or until the end of the contract between the provider service network and the agency, whichever is sooner. Beginning the second month after the determination of eligibility, the contractor may collect a monthly premium from each Medically Needy recipient provided the premium does not exceed the enrollee's share of cost as determined by the Department of Children and Families. The contractor must provide a 90-day grace period before disenrolling a Medically Needy recipient for failure to pay premiums. The contractor may earn an administrative fee, if the fee is less than any savings determined by the reconciliation process pursuant to s. 409.912(4)(d)1. Premium revenue collected from the recipients shall be deducted from the contractor's earned savings. This subsection expires October 1, 2014, or upon full implementation of the managed medical assistance program, whichever is sooner.~~

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

(a) Except as provided in paragraphs (b) and (c), expenditures shall be classified in a manner consistent with 45 C.F.R. part 158.

(b) Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.

(c) Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period.

Reviser's note.—Amended to conform to the repeals of numerous subunits pursuant to their own terms, effective at various dates in 2013 and 2014.

Section 17. Subsection (15) of section 430.04, Florida Statutes, is repealed.

Reviser's note.—The cited subsection, which relates to authorization of the Department of Elderly Affairs to administer all Medicaid waivers and programs relating to elders and their appropriations, expired pursuant to its own terms, effective October 1, 2014.

Section 18. Subsections (10), (11), and (12) of section 430.502, Florida Statutes, are repealed.

Reviser's note.—The cited subsections relate to seeking of a federal waiver to implement a Medicaid home and community-based waiver targeted to persons with Alzheimer's disease to test the effectiveness of Alzheimer's specific interventions to delay or to avoid institutional placement. Subsection (12) provides that authority to continue the waiver program is automatically eliminated at the close of the 2010 Regular Session of the Legislature unless further action is taken to continue it before such time.

Section 19. Subsection (5) of section 443.131, Florida Statutes, is repealed.

Reviser's note.—The cited subsection, which relates to an additional rate for interest on federal advances received by the Unemployment Compensation Trust Fund, expired pursuant to its own terms, effective July 1, 2014.

Section 20. Subsection (1) of section 576.061, Florida Statutes, is amended to read:

576.061 Plant nutrient investigational allowances, deficiencies, and penalties.—

(1) A commercial fertilizer is deemed deficient if the analysis of any nutrient is below the guarantee by an amount exceeding the investigational allowances. The department shall adopt rules, which shall take effect on July 1, 2014, that establish the investigational allowances used to determine whether a fertilizer is deficient in plant food.

~~(a) Effective July 1, 2014, this paragraph and paragraphs (b)-(f) are repealed. Until July 1, 2014, investigational allowances shall be set as provided in paragraphs (b)-(f).~~

~~(b) *Primary plant nutrients; investigational allowances.*—~~

~~Guaranteed Percent~~	~~Total Nitrogen Percent~~	~~Available Phosphate Percent~~	~~Potash Percent~~
~~04 or less~~	~~0.49~~	~~0.67~~	~~0.41~~
~~05~~	~~0.51~~	~~0.67~~	~~0.43~~
~~06~~	~~0.52~~	~~0.67~~	~~0.47~~
~~07~~	~~0.54~~	~~0.68~~	~~0.53~~
~~08~~	~~0.55~~	~~0.68~~	~~0.60~~
~~09~~	~~0.57~~	~~0.68~~	~~0.65~~
~~10~~	~~0.58~~	~~0.69~~	~~0.70~~
~~12~~	~~0.61~~	~~0.69~~	~~0.79~~
~~14~~	~~0.63~~	~~0.70~~	~~0.87~~

Guaranteed Percent	Total Nitrogen Percent	Available Phosphate Percent	Potash Percent
16	0.67	0.70	0.94
18	0.70	0.71	1.01
20	0.73	0.72	1.08
22	0.75	0.72	1.15
24	0.78	0.73	1.21
26	0.81	0.73	1.27
28	0.83	0.74	1.33
30	0.86	0.75	1.39
32 or more	0.88	0.76	1.44

For guarantees not listed, calculate the appropriate value by interpolation.

(c) *Nitrogen investigational allowances.*—

Nitrogen Breakdown	Investigational Allowances Percent
Nitrate nitrogen	0.40
Ammoniacal nitrogen	0.40
Water soluble nitrogen or urea nitrogen	0.40
Water insoluble nitrogen	0.30

In no case may the investigational allowance exceed 50 percent of the amount guaranteed.

(d) *Secondary and micro plant nutrients, total or soluble.*—

Element	Investigational Allowances Percent
Calcium	0.2 unit + 5 percent of guarantee
Magnesium	0.2 unit + 5 percent of guarantee
Sulfur (free and combined)	0.2 unit + 5 percent of guarantee
Boron	0.003 unit + 15 percent of guarantee
Cobalt	0.0001 unit + 30 percent of guarantee
Chlorine	0.005 unit + 10 percent of guarantee
Copper	0.005 unit + 10 percent of guarantee
Iron	0.005 unit + 10 percent of guarantee
Manganese	0.005 unit + 10 percent of guarantee
Molybdenum	0.0001 unit + 30 percent of guarantee
Sodium	0.005 unit + 10 percent of guarantee
Zinc	0.005 unit + 10 percent of guarantee

The maximum allowance for secondary and minor elements when calculated in accordance with this section is 1 unit (1 percent). In no case, however, may the investigational allowance exceed 50 percent of the amount guaranteed.

~~(e) *Liming materials and gypsum.*—~~

~~Range Percent~~	~~Investigational Allowances Percent~~
~~0-10~~	~~0.30~~
~~Over 10-25~~	~~0.40~~
~~Over 25~~	~~0.50~~

~~(f) *Pesticides in fertilizer mixtures.*—An investigational allowance of 25 percent of the guarantee shall be allowed on all pesticides when added to custom blend fertilizers.~~

Reviser's note.—The cited paragraphs, which relate to investigational allowances for fertilizer, were repealed pursuant to their own terms, effective July 1, 2014.

Section 21. Section 624.351, Florida Statutes, is repealed.

Reviser's note.—The cited section, which relates to the Medicaid and Public Assistance Fraud Strike Force, was repealed pursuant to its own terms, effective June 30, 2014.

Section 22. Section 624.352, Florida Statutes, is repealed.

Reviser's note.—The cited section, which relates to interagency agreements to detect and deter Medicaid and public assistance fraud, was repealed pursuant to its own terms, effective June 30, 2014.

Section 23. Subsection (7) of section 626.2815, Florida Statutes, is repealed.

Reviser's note.—The cited subsection, which relates to a requirement that persons holding a license to solicit or sell life insurance must complete a minimum of 3 hours in continuing education on the subject of suitability in annuity and life insurance transactions, was deleted from s. 626.2815 by s. 11, ch. 2012-209, Laws of Florida, effective October 1, 2014. Since the subsection was not repealed by a "current session" of the Legislature, it may be omitted from the 2015 Florida Statutes only through a reviser's bill duly enacted by the Legislature. See s. 11.242(5)(b) and (i).

Section 24. Paragraph (b) of subsection (4) of section 828.27, Florida Statutes, is amended to read:

828.27 Local animal control or cruelty ordinances; penalty.—

(4)

(b)~~1.~~ The governing body of a county or municipality may impose and collect a surcharge of up to $5 upon each civil penalty imposed for violation of an ordinance relating to animal control or cruelty. The proceeds from such

surcharges shall be used to pay the costs of training for animal control officers.

~~2. In addition to the uses set forth in subparagraph 1., a county, as defined in s. 125.011, may use the proceeds specified in that subparagraph and any carryover or fund balance from such proceeds for animal shelter operating expenses. This subparagraph expires July 1, 2014.~~

Reviser's note.—Amended to delete subparagraph (4)(b)2., which expired pursuant to its own terms, effective July 1, 2014.

Section 25. Paragraph (e) of subsection (9) of section 1002.32, Florida Statutes, is amended to read:

1002.32 Developmental research (laboratory) schools.—

(9) FUNDING.—Funding for a lab school, including a charter lab school, shall be provided as follows:

(e)~~1.~~ Each lab school shall receive funds for capital improvement purposes in an amount determined as follows: multiply the maximum allowable nonvoted discretionary millage for capital improvements pursuant to s. 1011.71(2) by 96 percent of the current year's taxable value for school purposes for the district in which each lab school is located; divide the result by the total full-time equivalent membership of the district; and multiply the result by the full-time equivalent membership of the lab school. The amount obtained shall be discretionary capital improvement funds and shall be appropriated from state funds in the General Appropriations Act to the Lab School Educational Facility Trust Fund.

~~2. Notwithstanding the provisions of subparagraph 1., for the 2013-2014 fiscal year, funds appropriated for capital improvement purposes shall be divided between lab schools based on full-time equivalent student membership. This subparagraph expires July 1, 2014.~~

Reviser's note.—Amended to delete subparagraph (9)(e)2., which expired pursuant to its own terms, effective July 1, 2014.

Section 26. Subsection (4) of section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency for the purpose of developing a Medicaid preferred drug list.

(4) Upon recommendation of the committee, the agency shall adopt a preferred drug list as described in s. 409.912(8) ~~409.912(37)~~. To the extent feasible, the committee shall review all drug classes included on the preferred drug list every 12 months, and may recommend additions to and deletions from the preferred drug list, such that the preferred drug list

provides for medically appropriate drug therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

Reviser's note.—Amended to conform to the redesignation of subunits of s. 409.912 by this act.

Section 27. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

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

(1) The rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebate, and other trade secrets as defined in s. 688.002 that the agency has identified for use in negotiations, held by the Agency for Health Care Administration under s. 409.912(8)(a)7. ~~409.912(37)(a)7.~~ are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Reviser's note.—Amended to conform to the redesignation of subunits of s. 409.912 by this act.

Section 28. Subsections (1), (6), (12), and (13) of section 409.962, Florida Statutes, are amended to read:

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

(1) "Accountable care organization" means an entity qualified as an accountable care organization in accordance with federal regulations, and which meets the requirements of a provider service network as described in s. 409.912(2) ~~409.912(4)(d)~~.

(6) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(2) ~~409.912(4)(d)~~ or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

(12) "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(2) ~~409.912(4)(d)~~, in the state and is paid a prospective per-member, per-month payment by the agency.

(13) "Provider service network" means an entity qualified pursuant to s. 409.912(2) ~~409.912(4)(d)~~ of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

Reviser's note.—Amended to conform to the redesignation of subunits of s. 409.912 by this act.

Section 29. Section 636.0145, Florida Statutes, is amended to read:

636.0145 Certain entities contracting with Medicaid.—~~Notwithstanding the requirements of s. 409.912(4)(b),~~ An entity that is providing comprehensive inpatient and outpatient mental health care services to certain Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties through a capitated, prepaid arrangement pursuant to the federal waiver provided for in s. 409.905(5) must become licensed under this chapter by December 31, 1998. Any entity licensed under this chapter which provides services solely to Medicaid recipients under a contract with Medicaid is exempt from ss. 636.017, 636.018, 636.022, 636.028, 636.034, and 636.066(1).

Reviser's note.—Amended to conform to the deletion of s. 409.912(4)(b) by this act to conform to its expiration pursuant to its own terms, effective October 1, 2014.

Section 30. Subsection (22) of section 641.19, Florida Statutes, is amended to read:

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

(22) "Provider service network" means a network authorized under s. 409.912(2) ~~409.912(4)(d)~~, reimbursed on a prepaid basis, operated by a health care provider or group of affiliated health care providers, and which directly provides health care services under a Medicare, Medicaid, or Healthy Kids contract.

Reviser's note.—Amended to conform to the redesignation of subunits of s. 409.912 by this act.

Section 31. Subsection (3) of section 641.225, Florida Statutes, is amended to read:

641.225 Surplus requirements.—

~~(3)(a) An entity providing prepaid capitated services which is authorized under s. 409.912(4)(a) and which applies for a certificate of authority is subject to the minimum surplus requirements set forth in subsection (1), unless the entity is backed by the full faith and credit of the county in which it is located.~~

~~(b) An entity providing prepaid capitated services which is authorized under s. 409.912(4)(b) or (c), and which applies for a certificate of authority is subject to the minimum surplus requirements set forth in s. 409.912.~~

Reviser's note.—Amended to conform to the expiration of paragraphs (4)(a)-(c) of s. 409.912 pursuant to their own terms, effective October 1, 2014, and confirmation of the expiration by this act.

Section 32. Subsection (4) of section 641.386, Florida Statutes, is amended to read:

641.386 Agent licensing and appointment required; exceptions.—

(4) All agents and health maintenance organizations shall comply with and be subject to the applicable provisions of ss. 641.309 and 409.912(5) ~~409.912(20)~~, and all companies and entities appointing agents shall comply with s. 626.451, when marketing for any health maintenance organization licensed pursuant to this part, including those organizations under contract with the Agency for Health Care Administration to provide health care services to Medicaid recipients or any private entity providing health care services to Medicaid recipients pursuant to a prepaid health plan contract with the Agency for Health Care Administration.

Reviser's note.—Amended to conform to the redesignation of subunits of s. 409.912 by this act.

Section 33. This act shall take effect on the 60th day after adjournment sine die of the session of the Legislature in which enacted.

Approved by the Governor March 19, 2015.

Filed in Office Secretary of State March 19, 2015.