1 A bill to be entitled
2 An act relating to health care; providing an
3 appropriation for a feasibility study relating
4 to outsourcing specified functions of the Board
5 of Dentistry; amending s. 409.8177, F.S.;
6 requiring the agency to contract for an
7 evaluation of the Florida Kidcare program;
8 amending s. 409.904, F.S.; revising provisions
9 governing optional payments for medical
10 assistance and related services; amending s.
11 409.905, F.S.; providing additional criteria
12 for the agency to adjust a hospital's inpatient
13 per diem rate for Medicaid; amending s.
14 409.906, F.S.; authorizing the agency to make
15 payments for specified services which are
16 optional under Title XIX of the Social Security
17 Act; amending s. 409.912, F.S.; revising
18 provisions governing the purchase of goods and
19 services for Medicaid recipients; providing for
20 quarterly reports to the Governor and presiding
21 officers of the Legislature; amending s.
22 409.9116, F.S.; revising the disproportionate
23 share/financial assistance program for rural
24 hospitals; amending s. 409.9122, F.S.; revising
25 provisions governing mandatory Medicaid managed
26 care enrollment; amending s. 499.012, F.S.;
27 redefining the term "wholesale distribution"
28 with respect to regulation of distribution of
29 prescription drugs; requiring the Agency for
30 Health Care Administration to conduct a study
31 of health care services provided to medically

1 fragile or medical-technology-dependent
2 children; requiring the Agency for Health Care
3 Administration to conduct a pilot program for a
4 subacute pediatric transitional care center;
5 requiring background screening of center
6 personnel; requiring the agency to amend the
7 Medicaid state plan and seek federal waivers as
8 necessary; requiring the center to have an
9 advisory board; providing for membership on the
10 advisory board; providing requirements for the
11 admission, transfer, and discharge of a child
12 to the center; requiring the agency to submit
13 certain reports to the Legislature; providing
14 guidelines for the agency to distribute
15 disproportionate share funds during the
16 2002-2003 fiscal year; authorizing the Agency
17 for Health Care Administration to conduct a
18 pilot project on overnight stays in an
19 ambulatory surgical center; amending s. 624.91,
20 F.S.; revising duties of the Florida Healthy
21 Kids Corporation with respect to annual
22 determination of participation in the Healthy
23 Kids Program; prescribing duties of the
24 corporation in establishing local match
25 requirements; revising the composition of the
26 board of directors; providing an effective
27 date.
28
29 Be It Enacted by the Legislature of the State of Florida:
30
31

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Section 1. Section 409.8177, Florida Statutes, is amended to read:

409.8177 Program evaluation.--

(1) The agency, in consultation with the Department of Health, the Department of Children and Family Services, and the Florida Healthy Kids Corporation, shall contract for an evaluation of the Florida Kidcare program and shall by January 1 of each year submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of the ~~Florida Kidcare~~ program. In addition to the items specified under s. 2108 of Title XXI of the Social Security Act, the report shall include an assessment of crowd-out and access to health care, as well as the following:

(a)~~(1)~~ An assessment of the operation of the program, including the progress made in reducing the number of uncovered low-income children.

(b)~~(2)~~ An assessment of the effectiveness in increasing the number of children with creditable health coverage, including an assessment of the impact of outreach.

(c)~~(3)~~ The characteristics of the children and families assisted under the program, including ages of the children, family income, and access to or coverage by other health insurance prior to the program and after disenrollment from the program.

(d)~~(4)~~ The quality of health coverage provided, including the types of benefits provided.

(e)~~(5)~~ The amount and level, including payment of part or all of any premium, of assistance provided.

(f)~~(6)~~ The average length of coverage of a child under the program.

1 (g)~~(7)~~ The program's choice of health benefits
2 coverage and other methods used for providing child health
3 assistance.
4 (h)~~(8)~~ The sources of nonfederal funding used in the
5 program.
6 (i)~~(9)~~ An assessment of the effectiveness of Medikids,
7 Children's Medical Services network, and other public and
8 private programs in the state in increasing the availability
9 of affordable quality health insurance and health care for
10 children.
11 (j)~~(10)~~ A review and assessment of state activities to
12 coordinate the program with other public and private programs.
13 (k)~~(11)~~ An analysis of changes and trends in the state
14 that affect the provision of health insurance and health care
15 to children.
16 (l)~~(12)~~ A description of any plans the state has for
17 improving the availability of health insurance and health care
18 for children.
19 (m)~~(13)~~ Recommendations for improving the program.
20 (n)~~(14)~~ Other studies as necessary.
21 (2) The agency shall also submit each month to the
22 Governor, the President of the Senate, and the Speaker of the
23 House of Representatives a report of enrollment for each
24 program component of the Florida Kidcare program.
25 Section 2. Effective July 1, 2002, subsection (2) of
26 section 409.904, Florida Statutes, as amended by section 2 of
27 chapter 2001-377, Laws of Florida, is amended to read:
28 409.904 Optional payments for eligible persons.--The
29 agency may make payments for medical assistance and related
30 services on behalf of the following persons who are determined
31 to be eligible subject to the income, assets, and categorical

eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(2)~~(a)~~ A family, a pregnant woman, a child under age 19 who would otherwise qualify for Florida Kidcare Medicaid, a child up to age 21 who would otherwise qualify under s. 409.903(1), a person age 65 or over, or a blind or disabled person who would otherwise be eligible for Florida Medicaid, except that the income or assets of such family or person exceed established limitations.~~A pregnant woman who would otherwise qualify for Medicaid under s. 409.903(5) except for her level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy. A pregnant woman who applies for medically needy eligibility may not be made presumptively eligible.~~

~~(b) A child under age 21 who would otherwise qualify for Medicaid or the Florida Kidcare program except for the family's level of income and whose assets fall within the limits established by the Department of Children and Family Services for the medically needy.~~

For a family or person in this group, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. Expenses used to meet spend-down liability are not reimbursable by Medicaid. The medically-needy income levels in effect on July 1, 2001, are increased by $270 effective July 1, 2002.A family or person in this group, which group is known as the "medically needy," is eligible to receive the same services as other

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1 Medicaid recipients, with the exception of services in skilled
2 nursing facilities and intermediate care facilities for the
3 developmentally disabled.
4 Section 3. Paragraph (c) of subsection (5) of section
5 409.905, Florida Statutes, is amended to read:
6 409.905 Mandatory Medicaid services.--The agency may
7 make payments for the following services, which are required
8 of the state by Title XIX of the Social Security Act,
9 furnished by Medicaid providers to recipients who are
10 determined to be eligible on the dates on which the services
11 were provided. Any service under this section shall be
12 provided only when medically necessary and in accordance with
13 state and federal law. Mandatory services rendered by
14 providers in mobile units to Medicaid recipients may be
15 restricted by the agency. Nothing in this section shall be
16 construed to prevent or limit the agency from adjusting fees,
17 reimbursement rates, lengths of stay, number of visits, number
18 of services, or any other adjustments necessary to comply with
19 the availability of moneys and any limitations or directions
20 provided for in the General Appropriations Act or chapter 216.
21 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay
22 for all covered services provided for the medical care and
23 treatment of a recipient who is admitted as an inpatient by a
24 licensed physician or dentist to a hospital licensed under
25 part I of chapter 395. However, the agency shall limit the
26 payment for inpatient hospital services for a Medicaid
27 recipient 21 years of age or older to 45 days or the number of
28 days necessary to comply with the General Appropriations Act.
29 (c) Agency for Health Care Administration shall adjust
30 a hospital's current inpatient per diem rate to reflect the
31

1 cost of serving the Medicaid population at that institution
2 if:
3 1. The hospital experiences an increase in Medicaid
4 caseload by more than 25 percent in any year, primarily
5 resulting from the closure of a hospital in the same service
6 area occurring after July 1, 1995; ~~or~~
7 2. The hospital's Medicaid per diem rate is at least
8 25 percent below the Medicaid per patient cost for that year;
9 or~~.~~
10 3. The hospital is located in a county that has five
11 or fewer hospitals, began offering obstetrical services on or
12 after September 1999, and has submitted a request in writing
13 to the agency for a rate adjustment after July 1, 2000, but
14 before September 30, 2000, in which case such hospital's
15 Medicaid inpatient per diem rate shall be adjusted to cost,
16 effective July 1, 2002. Effective July 1, 2003, for subsequent
17 rate semesters, such hospital's rate will be set in accordance
18 with the methodology of the Medicaid inpatient reimbursement
19 plan.
20
21 No later than October 1 of each year ~~November 1, 2001~~, the
22 agency must provide estimated costs for any adjustment in a
23 hospital inpatient per diem pursuant to this paragraph to the
24 Executive Office of the Governor, the House of Representatives
25 General Appropriations Committee, and the Senate
26 Appropriations Committee. Before the agency implements a
27 change in a hospital's inpatient per diem rate pursuant to
28 this paragraph, the Legislature must have specifically
29 appropriated sufficient funds in the General Appropriations
30 Act to support the increase in cost as estimated by the
31 agency.

1 Section 4. Effective July 1, 2002, subsections (1),
2 (12), and (23) of section 409.906, Florida Statutes, as
3 amended by section 3 of chapter 2001-377, Laws of Florida, are
4 amended to read:
5 409.906 Optional Medicaid services.--Subject to
6 specific appropriations, the agency may make payments for
7 services which are optional to the state under Title XIX of
8 the Social Security Act and are furnished by Medicaid
9 providers to recipients who are determined to be eligible on
10 the dates on which the services were provided. Any optional
11 service that is provided shall be provided only when medically
12 necessary and in accordance with state and federal law.
13 Optional services rendered by providers in mobile units to
14 Medicaid recipients may be restricted or prohibited by the
15 agency. Nothing in this section shall be construed to prevent
16 or limit the agency from adjusting fees, reimbursement rates,
17 lengths of stay, number of visits, or number of services, or
18 making any other adjustments necessary to comply with the
19 availability of moneys and any limitations or directions
20 provided for in the General Appropriations Act or chapter 216.
21 If necessary to safeguard the state's systems of providing
22 services to elderly and disabled persons and subject to the
23 notice and review provisions of s. 216.177, the Governor may
24 direct the Agency for Health Care Administration to amend the
25 Medicaid state plan to delete the optional Medicaid service
26 known as "Intermediate Care Facilities for the Developmentally
27 Disabled." Optional services may include:
28 (1) ADULT DENTURE SERVICES.--The agency may pay for
29 dentures, the procedures required to seat dentures, and the
30 repair and reline of dentures, provided by or under the
31 direction of a licensed dentist, for a recipient who is age 21

or older. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

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

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

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

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

~~(e) This subsection is repealed July 1, 2002.~~

(12) ~~CHILDREN'S~~ HEARING SERVICES.--The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient ~~under age 21~~ by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(23) ~~CHILDREN'S~~ VISUAL SERVICES.--The agency may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient ~~under age 21~~, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

Section 5. Section 409.912, Florida Statutes, as amended by sections 8 and 9 of chapter 2001-377, Laws of Florida, 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. 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 may establish prior authorization requirements 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, established pursuant to s. 409.91195, shall make recommendations to the agency on drugs for which prior authorization is required, and~~.~~ the agency shall inform the ~~Pharmaceutical and Therapeutics~~ committee of its decisions regarding drugs subject to prior authorization.

(1) 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.

1 (2) The agency may contract with health maintenance
2 organizations certified pursuant to part I of chapter 641 for
3 the provision of services to recipients.
4 (3) The agency may contract with:
5 (a) An entity that provides no prepaid health care
6 services other than Medicaid services under contract with the
7 agency and which is owned and operated by a county, county
8 health department, or county-owned and operated hospital to
9 provide health care services on a prepaid or fixed-sum basis
10 to recipients, which entity may provide such prepaid services
11 either directly or through arrangements with other providers.
12 Such prepaid health care services entities must be licensed
13 under parts I and III by January 1, 1998, and until then are
14 exempt from the provisions of part I of chapter 641. An entity
15 recognized under this paragraph which demonstrates to the
16 satisfaction of the Department of Insurance that it is backed
17 by the full faith and credit of the county in which it is
18 located may be exempted from s. 641.225.
19 (b) An entity that is providing comprehensive
20 behavioral health care services to certain Medicaid recipients
21 through a capitated, prepaid arrangement pursuant to the
22 federal waiver provided for by s. 409.905(5). Such an entity
23 must be licensed under chapter 624, chapter 636, or chapter
24 641 and must possess the clinical systems and operational
25 competence to manage risk and provide comprehensive behavioral
26 health care to Medicaid recipients. As used in this paragraph,
27 the term "comprehensive behavioral health care services" means
28 covered mental health and substance abuse treatment services
29 that are available to Medicaid recipients. The secretary of
30 the Department of Children and Family Services shall approve
31 provisions of procurements related to children in the

1 department's care or custody prior to enrolling such children
2 in a prepaid behavioral health plan. Any contract awarded
3 under this paragraph must be competitively procured. In
4 developing the behavioral health care prepaid plan procurement
5 document, the agency shall ensure that the procurement
6 document requires the contractor to develop and implement a
7 plan to ensure compliance with s. 394.4574 related to services
8 provided to residents of licensed assisted living facilities
9 that hold a limited mental health license. The agency must
10 ensure that Medicaid recipients have available the choice of
11 at least two managed care plans for their behavioral health
12 care services. The agency may reimburse for
13 substance-abuse-treatment services on a fee-for-service basis
14 until the agency finds that adequate funds are available for
15 capitated, prepaid arrangements.
16 1. By January 1, 2001, the agency shall modify the
17 contracts with the entities providing comprehensive inpatient
18 and outpatient mental health care services to Medicaid
19 recipients in Hillsborough, Highlands, Hardee, Manatee, and
20 Polk Counties, to include substance-abuse-treatment services.
21 2. By December 31, 2001, the agency shall contract
22 with entities providing comprehensive behavioral health care
23 services to Medicaid recipients through capitated, prepaid
24 arrangements in Charlotte, Collier, DeSoto, Escambia, Glades,
25 Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota,
26 and Walton Counties. The agency may contract with entities
27 providing comprehensive behavioral health care services to
28 Medicaid recipients through capitated, prepaid arrangements in
29 Alachua County. The agency may determine if Sarasota County
30 shall be included as a separate catchment area or included in
31 any other agency geographic area.

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1 3. Children residing in a Department of Juvenile
2 Justice residential program approved as a Medicaid behavioral
3 health overlay services provider shall not be included in a
4 behavioral health care prepaid health plan pursuant to this
5 paragraph.
6 4. In converting to a prepaid system of delivery, the
7 agency shall in its procurement document require an entity
8 providing comprehensive behavioral health care services to
9 prevent the displacement of indigent care patients by
10 enrollees in the Medicaid prepaid health plan providing
11 behavioral health care services from facilities receiving
12 state funding to provide indigent behavioral health care, to
13 facilities licensed under chapter 395 which do not receive
14 state funding for indigent behavioral health care, or
15 reimburse the unsubsidized facility for the cost of behavioral
16 health care provided to the displaced indigent care patient.
17 5. Traditional community mental health providers under
18 contract with the Department of Children and Family Services
19 pursuant to part IV of chapter 394 and inpatient mental health
20 providers licensed pursuant to chapter 395 must be offered an
21 opportunity to accept or decline a contract to participate in
22 any provider network for prepaid behavioral health services.
23 (c) A federally qualified health center or an entity
24 owned by one or more federally qualified health centers or an
25 entity owned by other migrant and community health centers
26 receiving non-Medicaid financial support from the Federal
27 Government to provide health care services on a prepaid or
28 fixed-sum basis to recipients. Such prepaid health care
29 services entity must be licensed under parts I and III of
30 chapter 641, but shall be prohibited from serving Medicaid
31 recipients on a prepaid basis, until such licensure has been

1 obtained. However, such an entity is exempt from s. 641.225
2 if the entity meets the requirements specified in subsections
3 (14) and (15).
4 (d) No more than four provider service networks for
5 demonstration projects to test Medicaid direct contracting.
6 The demonstration projects may be reimbursed on a
7 fee-for-service or prepaid basis. A provider service network
8 which is reimbursed by the agency on a prepaid basis shall be
9 exempt from parts I and III of chapter 641, but must meet
10 appropriate financial reserve, quality assurance, and patient
11 rights requirements as established by the agency. The agency
12 shall award contracts on a competitive bid basis and shall
13 select bidders based upon price and quality of care. Medicaid
14 recipients assigned to a demonstration project shall be chosen
15 equally from those who would otherwise have been assigned to
16 prepaid plans and MediPass. The agency is authorized to seek
17 federal Medicaid waivers as necessary to implement the
18 provisions of this section. A demonstration project awarded
19 pursuant to this paragraph shall be for 4 years from the date
20 of implementation.
21 (e) An entity that provides comprehensive behavioral
22 health care services to certain Medicaid recipients through an
23 administrative services organization agreement. Such an entity
24 must possess the clinical systems and operational competence
25 to provide comprehensive health care to Medicaid recipients.
26 As used in this paragraph, the term "comprehensive behavioral
27 health care services" means covered mental health and
28 substance abuse treatment services that are available to
29 Medicaid recipients. Any contract awarded under this paragraph
30 must be competitively procured. The agency must ensure that
31

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1 Medicaid recipients have available the choice of at least two
2 managed care plans for their behavioral health care services.
3 (f) An entity in Pasco County or Pinellas County that
4 provides in-home physician services to Medicaid recipients
5 with degenerative neurological diseases in order to test the
6 cost-effectiveness of enhanced home-based medical care. The
7 entity providing the services shall be reimbursed on a
8 fee-for-service basis at a rate not less than comparable
9 Medicare reimbursement rates. The agency may apply for waivers
10 of federal regulations necessary to implement such program.
11 This paragraph shall be repealed on July 1, 2002.
12 (g) Children's provider networks that provide care
13 coordination and care management for Medicaid-eligible
14 pediatric patients, primary care, authorization of specialty
15 care, and other urgent and emergency care through organized
16 providers designed to service Medicaid eligibles under age 18
17 and pediatric emergency departments' diversion programs. The
18 networks shall provide after-hour operations, including
19 evening and weekend hours, to promote, when appropriate, the
20 use of the children's networks rather than hospital emergency
21 departments.
22 (4) The agency may contract with any public or private
23 entity otherwise authorized by this section on a prepaid or
24 fixed-sum basis for the provision of health care services to
25 recipients. An entity may provide prepaid services to
26 recipients, either directly or through arrangements with other
27 entities, if each entity involved in providing services:
28 (a) Is organized primarily for the purpose of
29 providing health care or other services of the type regularly
30 offered to Medicaid recipients;
31

1 (b) Ensures that services meet the standards set by
2 the agency for quality, appropriateness, and timeliness;
3 (c) Makes provisions satisfactory to the agency for
4 insolvency protection and ensures that neither enrolled
5 Medicaid recipients nor the agency will be liable for the
6 debts of the entity;
7 (d) Submits to the agency, if a private entity, a
8 financial plan that the agency finds to be fiscally sound and
9 that provides for working capital in the form of cash or
10 equivalent liquid assets excluding revenues from Medicaid
11 premium payments equal to at least the first 3 months of
12 operating expenses or $200,000, whichever is greater;
13 (e) Furnishes evidence satisfactory to the agency of
14 adequate liability insurance coverage or an adequate plan of
15 self-insurance to respond to claims for injuries arising out
16 of the furnishing of health care;
17 (f) Provides, through contract or otherwise, for
18 periodic review of its medical facilities and services, as
19 required by the agency; and
20 (g) Provides organizational, operational, financial,
21 and other information required by the agency.
22 (5) The agency may contract on a prepaid or fixed-sum
23 basis with any health insurer that:
24 (a) Pays for health care services provided to enrolled
25 Medicaid recipients in exchange for a premium payment paid by
26 the agency;
27 (b) Assumes the underwriting risk; and
28 (c) Is organized and licensed under applicable
29 provisions of the Florida Insurance Code and is currently in
30 good standing with the Department of Insurance.
31

1 (6) The agency may contract on a prepaid or fixed-sum
2 basis with an exclusive provider organization to provide
3 health care services to Medicaid recipients provided that the
4 exclusive provider organization meets applicable managed care
5 plan requirements in this section, ss. 409.9122, 409.9123,
6 409.9128, and 627.6472, and other applicable provisions of
7 law.
8 (7) The Agency for Health Care Administration may
9 provide cost-effective purchasing of chiropractic services on
10 a fee-for-service basis to Medicaid recipients through
11 arrangements with a statewide chiropractic preferred provider
12 organization incorporated in this state as a not-for-profit
13 corporation. The agency shall ensure that the benefit limits
14 and prior authorization requirements in the current Medicaid
15 program shall apply to the services provided by the
16 chiropractic preferred provider organization.
17 (8) The agency shall not contract on a prepaid or
18 fixed-sum basis for Medicaid services with an entity which
19 knows or reasonably should know that any officer, director,
20 agent, managing employee, or owner of stock or beneficial
21 interest in excess of 5 percent common or preferred stock, or
22 the entity itself, has been found guilty of, regardless of
23 adjudication, or entered a plea of nolo contendere, or guilty,
24 to:
25 (a) Fraud;
26 (b) Violation of federal or state antitrust statutes,
27 including those proscribing price fixing between competitors
28 and the allocation of customers among competitors;
29 (c) Commission of a felony involving embezzlement,
30 theft, forgery, income tax evasion, bribery, falsification or
31 destruction of records, making false statements, receiving

1 stolen property, making false claims, or obstruction of
2 justice; or
3 (d) Any crime in any jurisdiction which directly
4 relates to the provision of health services on a prepaid or
5 fixed-sum basis.
6 (9) The agency, after notifying the Legislature, may
7 apply for waivers of applicable federal laws and regulations
8 as necessary to implement more appropriate systems of health
9 care for Medicaid recipients and reduce the cost of the
10 Medicaid program to the state and federal governments and
11 shall implement such programs, after legislative approval,
12 within a reasonable period of time after federal approval.
13 These programs must be designed primarily to reduce the need
14 for inpatient care, custodial care and other long-term or
15 institutional care, and other high-cost services.
16 (a) Prior to seeking legislative approval of such a
17 waiver as authorized by this subsection, the agency shall
18 provide notice and an opportunity for public comment. Notice
19 shall be provided to all persons who have made requests of the
20 agency for advance notice and shall be published in the
21 Florida Administrative Weekly not less than 28 days prior to
22 the intended action.
23 (b) Notwithstanding s. 216.292, funds that are
24 appropriated to the Department of Elderly Affairs for the
25 Assisted Living for the Elderly Medicaid waiver and are not
26 expended shall be transferred to the agency to fund
27 Medicaid-reimbursed nursing home care.
28 (10) The agency shall establish a postpayment
29 utilization control program designed to identify recipients
30 who may inappropriately overuse or underuse Medicaid services
31 and shall provide methods to correct such misuse.

1 (11) The agency shall develop and provide coordinated
2 systems of care for Medicaid recipients and may contract with
3 public or private entities to develop and administer such
4 systems of care among public and private health care providers
5 in a given geographic area.
6 (12) The agency shall operate or contract for the
7 operation of utilization management and incentive systems
8 designed to encourage cost-effective use services.
9 (13)(a) The agency shall identify health care
10 utilization and price patterns within the Medicaid program
11 which are not cost-effective or medically appropriate and
12 assess the effectiveness of new or alternate methods of
13 providing and monitoring service, and may implement such
14 methods as it considers appropriate. Such methods may include
15 disease management initiatives, an integrated and systematic
16 approach for managing the health care needs of recipients who
17 are at risk of or diagnosed with a specific disease by using
18 best practices, prevention strategies, clinical-practice
19 improvement, clinical interventions and protocols, outcomes
20 research, information technology, and other tools and
21 resources to reduce overall costs and improve measurable
22 outcomes.
23 (b) The responsibility of the agency under this
24 subsection shall include the development of capabilities to
25 identify actual and optimal practice patterns; patient and
26 provider educational initiatives; methods for determining
27 patient compliance with prescribed treatments; fraud, waste,
28 and abuse prevention and detection programs; and beneficiary
29 case management programs.
30 1. The practice pattern identification program shall
31 evaluate practitioner prescribing patterns based on national

1 and regional practice guidelines, comparing practitioners to
2 their peer groups. The agency and its Drug Utilization Review
3 Board shall consult with a panel of practicing health care
4 professionals consisting of the following: the Speaker of the
5 House of Representatives and the President of the Senate shall
6 each appoint three physicians licensed under chapter 458 or
7 chapter 459; and the Governor shall appoint two pharmacists
8 licensed under chapter 465 and one dentist licensed under
9 chapter 466 who is an oral surgeon. Terms of the panel members
10 shall expire at the discretion of the appointing official. The
11 panel shall begin its work by August 1, 1999, regardless of
12 the number of appointments made by that date. The advisory
13 panel shall be responsible for evaluating treatment guidelines
14 and recommending ways to incorporate their use in the practice
15 pattern identification program. Practitioners who are
16 prescribing inappropriately or inefficiently, as determined by
17 the agency, may have their prescribing of certain drugs
18 subject to prior authorization.
19 2. The agency shall also develop educational
20 interventions designed to promote the proper use of
21 medications by providers and beneficiaries.
22 3. The agency shall implement a pharmacy fraud, waste,
23 and abuse initiative that may include a surety bond or letter
24 of credit requirement for participating pharmacies, enhanced
25 provider auditing practices, the use of additional fraud and
26 abuse software, recipient management programs for
27 beneficiaries inappropriately using their benefits, and other
28 steps that will eliminate provider and recipient fraud, waste,
29 and abuse. The initiative shall address enforcement efforts to
30 reduce the number and use of counterfeit prescriptions.
31

1 4. The agency may apply for any federal waivers needed
2 to implement this paragraph.
3 (14) An entity contracting on a prepaid or fixed-sum
4 basis shall, in addition to meeting any applicable statutory
5 surplus requirements, also maintain at all times in the form
6 of cash, investments that mature in less than 180 days
7 allowable as admitted assets by the Department of Insurance,
8 and restricted funds or deposits controlled by the agency or
9 the Department of Insurance, a surplus amount equal to
10 one-and-one-half times the entity's monthly Medicaid prepaid
11 revenues. As used in this subsection, the term "surplus" means
12 the entity's total assets minus total liabilities. If an
13 entity's surplus falls below an amount equal to
14 one-and-one-half times the entity's monthly Medicaid prepaid
15 revenues, the agency shall prohibit the entity from engaging
16 in marketing and preenrollment activities, shall cease to
17 process new enrollments, and shall not renew the entity's
18 contract until the required balance is achieved. The
19 requirements of this subsection do not apply:
20 (a) Where a public entity agrees to fund any deficit
21 incurred by the contracting entity; or
22 (b) Where the entity's performance and obligations are
23 guaranteed in writing by a guaranteeing organization which:
24 1. Has been in operation for at least 5 years and has
25 assets in excess of $50 million; or
26 2. Submits a written guarantee acceptable to the
27 agency which is irrevocable during the term of the contracting
28 entity's contract with the agency and, upon termination of the
29 contract, until the agency receives proof of satisfaction of
30 all outstanding obligations incurred under the contract.
31

1 (15)(a) The agency may require an entity contracting
2 on a prepaid or fixed-sum basis to establish a restricted
3 insolvency protection account with a federally guaranteed
4 financial institution licensed to do business in this state.
5 The entity shall deposit into that account 5 percent of the
6 capitation payments made by the agency each month until a
7 maximum total of 2 percent of the total current contract
8 amount is reached. The restricted insolvency protection
9 account may be drawn upon with the authorized signatures of
10 two persons designated by the entity and two representatives
11 of the agency. If the agency finds that the entity is
12 insolvent, the agency may draw upon the account solely with
13 the two authorized signatures of representatives of the
14 agency, and the funds may be disbursed to meet financial
15 obligations incurred by the entity under the prepaid contract.
16 If the contract is terminated, expired, or not continued, the
17 account balance must be released by the agency to the entity
18 upon receipt of proof of satisfaction of all outstanding
19 obligations incurred under this contract.
20 (b) The agency may waive the insolvency protection
21 account requirement in writing when evidence is on file with
22 the agency of adequate insolvency insurance and reinsurance
23 that will protect enrollees if the entity becomes unable to
24 meet its obligations.
25 (16) An entity that contracts with the agency on a
26 prepaid or fixed-sum basis for the provision of Medicaid
27 services shall reimburse any hospital or physician that is
28 outside the entity's authorized geographic service area as
29 specified in its contract with the agency, and that provides
30 services authorized by the entity to its members, at a rate
31

1 negotiated with the hospital or physician for the provision of
2 services or according to the lesser of the following:
3 (a) The usual and customary charges made to the
4 general public by the hospital or physician; or
5 (b) The Florida Medicaid reimbursement rate
6 established for the hospital or physician.
7 (17) When a merger or acquisition of a Medicaid
8 prepaid contractor has been approved by the Department of
9 Insurance pursuant to s. 628.4615, the agency shall approve
10 the assignment or transfer of the appropriate Medicaid prepaid
11 contract upon request of the surviving entity of the merger or
12 acquisition if the contractor and the other entity have been
13 in good standing with the agency for the most recent 12-month
14 period, unless the agency determines that the assignment or
15 transfer would be detrimental to the Medicaid recipients or
16 the Medicaid program. To be in good standing, an entity must
17 not have failed accreditation or committed any material
18 violation of the requirements of s. 641.52 and must meet the
19 Medicaid contract requirements. For purposes of this section,
20 a merger or acquisition means a change in controlling interest
21 of an entity, including an asset or stock purchase.
22 (18) Any entity contracting with the agency pursuant
23 to this section to provide health care services to Medicaid
24 recipients is prohibited from engaging in any of the following
25 practices or activities:
26 (a) Practices that are discriminatory, including, but
27 not limited to, attempts to discourage participation on the
28 basis of actual or perceived health status.
29 (b) Activities that could mislead or confuse
30 recipients, or misrepresent the organization, its marketing
31

1 representatives, or the agency. Violations of this paragraph
2 include, but are not limited to:
3 1. False or misleading claims that marketing
4 representatives are employees or representatives of the state
5 or county, or of anyone other than the entity or the
6 organization by whom they are reimbursed.
7 2. False or misleading claims that the entity is
8 recommended or endorsed by any state or county agency, or by
9 any other organization which has not certified its endorsement
10 in writing to the entity.
11 3. False or misleading claims that the state or county
12 recommends that a Medicaid recipient enroll with an entity.
13 4. Claims that a Medicaid recipient will lose benefits
14 under the Medicaid program, or any other health or welfare
15 benefits to which the recipient is legally entitled, if the
16 recipient does not enroll with the entity.
17 (c) Granting or offering of any monetary or other
18 valuable consideration for enrollment, except as authorized by
19 subsection (21).
20 (d) Door-to-door solicitation of recipients who have
21 not contacted the entity or who have not invited the entity to
22 make a presentation.
23 (e) Solicitation of Medicaid recipients by marketing
24 representatives stationed in state offices unless approved and
25 supervised by the agency or its agent and approved by the
26 affected state agency when solicitation occurs in an office of
27 the state agency. The agency shall ensure that marketing
28 representatives stationed in state offices shall market their
29 managed care plans to Medicaid recipients only in designated
30 areas and in such a way as to not interfere with the
31 recipients' activities in the state office.

1 (f) Enrollment of Medicaid recipients.
2 (19) The agency may impose a fine for a violation of
3 this section or the contract with the agency by a person or
4 entity that is under contract with the agency. With respect
5 to any nonwillful violation, such fine shall not exceed $2,500
6 per violation. In no event shall such fine exceed an
7 aggregate amount of $10,000 for all nonwillful violations
8 arising out of the same action. With respect to any knowing
9 and willful violation of this section or the contract with the
10 agency, the agency may impose a fine upon the entity in an
11 amount not to exceed $20,000 for each such violation. In no
12 event shall such fine exceed an aggregate amount of $100,000
13 for all knowing and willful violations arising out of the same
14 action.
15 (20) A health maintenance organization or a person or
16 entity exempt from chapter 641 that is under contract with the
17 agency for the provision of health care services to Medicaid
18 recipients may not use or distribute marketing materials used
19 to solicit Medicaid recipients, unless such materials have
20 been approved by the agency. The provisions of this subsection
21 do not apply to general advertising and marketing materials
22 used by a health maintenance organization to solicit both
23 non-Medicaid subscribers and Medicaid recipients.
24 (21) Upon approval by the agency, health maintenance
25 organizations and persons or entities exempt from chapter 641
26 that are under contract with the agency for the provision of
27 health care services to Medicaid recipients may be permitted
28 within the capitation rate to provide additional health
29 benefits that the agency has found are of high quality, are
30 practicably available, provide reasonable value to the
31

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1 recipient, and are provided at no additional cost to the
2 state.
3 (22) The agency shall utilize the statewide health
4 maintenance organization complaint hotline for the purpose of
5 investigating and resolving Medicaid and prepaid health plan
6 complaints, maintaining a record of complaints and confirmed
7 problems, and receiving disenrollment requests made by
8 recipients.
9 (23) The agency shall require the publication of the
10 health maintenance organization's and the prepaid health
11 plan's consumer services telephone numbers and the "800"
12 telephone number of the statewide health maintenance
13 organization complaint hotline on each Medicaid identification
14 card issued by a health maintenance organization or prepaid
15 health plan contracting with the agency to serve Medicaid
16 recipients and on each subscriber handbook issued to a
17 Medicaid recipient.
18 (24) The agency shall establish a health care quality
19 improvement system for those entities contracting with the
20 agency pursuant to this section, incorporating all the
21 standards and guidelines developed by the Medicaid Bureau of
22 the Health Care Financing Administration as a part of the
23 quality assurance reform initiative. The system shall
24 include, but need not be limited to, the following:
25 (a) Guidelines for internal quality assurance
26 programs, including standards for:
27 1. Written quality assurance program descriptions.
28 2. Responsibilities of the governing body for
29 monitoring, evaluating, and making improvements to care.
30 3. An active quality assurance committee.
31 4. Quality assurance program supervision.

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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.

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1 3. Use quality indicators derived from the clinical
2 care standards or practice guidelines to screen and monitor
3 care and services delivered.
4 (c) Guidelines for external quality review of each
5 contractor which require: focused studies of patterns of care;
6 individual care review in specific situations; and followup
7 activities on previous pattern-of-care study findings and
8 individual-care-review findings. In designing the external
9 quality review function and determining how it is to operate
10 as part of the state's overall quality improvement system, the
11 agency shall construct its external quality review
12 organization and entity contracts to address each of the
13 following:
14 1. Delineating the role of the external quality review
15 organization.
16 2. Length of the external quality review organization
17 contract with the state.
18 3. Participation of the contracting entities in
19 designing external quality review organization review
20 activities.
21 4. Potential variation in the type of clinical
22 conditions and health services delivery issues to be studied
23 at each plan.
24 5. Determining the number of focused pattern-of-care
25 studies to be conducted for each plan.
26 6. Methods for implementing focused studies.
27 7. Individual care review.
28 8. Followup activities.
29 (25) In order to ensure that children receive health
30 care services for which an entity has already been
31 compensated, an entity contracting with the agency pursuant to

1 this section shall achieve an annual Early and Periodic
2 Screening, Diagnosis, and Treatment (EPSDT) Service screening
3 rate of at least 60 percent for those recipients continuously
4 enrolled for at least 8 months. The agency shall develop a
5 method by which the EPSDT screening rate shall be calculated.
6 For any entity which does not achieve the annual 60 percent
7 rate, the entity must submit a corrective action plan for the
8 agency's approval. If the entity does not meet the standard
9 established in the corrective action plan during the specified
10 timeframe, the agency is authorized to impose appropriate
11 contract sanctions. At least annually, the agency shall
12 publicly release the EPSDT Services screening rates of each
13 entity it has contracted with on a prepaid basis to serve
14 Medicaid recipients.
15 (26) The agency shall perform enrollments and
16 disenrollments for Medicaid recipients who are eligible for
17 MediPass or managed care plans. Notwithstanding the
18 prohibition contained in paragraph (18)(f), managed care plans
19 may perform preenrollments of Medicaid recipients under the
20 supervision of the agency or its agents. For the purposes of
21 this section, "preenrollment" means the provision of marketing
22 and educational materials to a Medicaid recipient and
23 assistance in completing the application forms, but shall not
24 include actual enrollment into a managed care plan. An
25 application for enrollment shall not be deemed complete until
26 the agency or its agent verifies that the recipient made an
27 informed, voluntary choice. The agency, in cooperation with
28 the Department of Children and Family Services, may test new
29 marketing initiatives to inform Medicaid recipients about
30 their managed care options at selected sites. The agency
31 shall report to the Legislature on the effectiveness of such

1 initiatives. The agency may contract with a third party to
2 perform managed care plan and MediPass enrollment and
3 disenrollment services for Medicaid recipients and is
4 authorized to adopt rules to implement such services. The
5 agency may adjust the capitation rate only to cover the costs
6 of a third-party enrollment and disenrollment contract, and
7 for agency supervision and management of the managed care plan
8 enrollment and disenrollment contract.
9 (27) Any lists of providers made available to Medicaid
10 recipients, MediPass enrollees, or managed care plan enrollees
11 shall be arranged alphabetically showing the provider's name
12 and specialty and, separately, by specialty in alphabetical
13 order.
14 (28) The agency shall establish an enhanced managed
15 care quality assurance oversight function, to include at least
16 the following components:
17 (a) At least quarterly analysis and followup,
18 including sanctions as appropriate, of managed care
19 participant utilization of services.
20 (b) At least quarterly analysis and followup,
21 including sanctions as appropriate, of quality findings of the
22 Medicaid peer review organization and other external quality
23 assurance programs.
24 (c) At least quarterly analysis and followup,
25 including sanctions as appropriate, of the fiscal viability of
26 managed care plans.
27 (d) At least quarterly analysis and followup,
28 including sanctions as appropriate, of managed care
29 participant satisfaction and disenrollment surveys.
30 (e) The agency shall conduct regular and ongoing
31 Medicaid recipient satisfaction surveys.

1
2 The analyses and followup activities conducted by the agency
3 under its enhanced managed care quality assurance oversight
4 function shall not duplicate the activities of accreditation
5 reviewers for entities regulated under part III of chapter
6 641, but may include a review of the finding of such
7 reviewers.
8 (29) Each managed care plan that is under contract
9 with the agency to provide health care services to Medicaid
10 recipients shall annually conduct a background check with the
11 Florida Department of Law Enforcement of all persons with
12 ownership interest of 5 percent or more or executive
13 management responsibility for the managed care plan and shall
14 submit to the agency information concerning any such person
15 who has been found guilty of, regardless of adjudication, or
16 has entered a plea of nolo contendere or guilty to, any of the
17 offenses listed in s. 435.03.
18 (30) The agency shall, by rule, develop a process
19 whereby a Medicaid managed care plan enrollee who wishes to
20 enter hospice care may be disenrolled from the managed care
21 plan within 24 hours after contacting the agency regarding
22 such request. The agency rule shall include a methodology for
23 the agency to recoup managed care plan payments on a pro rata
24 basis if payment has been made for the enrollment month when
25 disenrollment occurs.
26 (31) The agency and entities which contract with the
27 agency to provide health care services to Medicaid recipients
28 under this section or s. 409.9122 must comply with the
29 provisions of s. 641.513 in providing emergency services and
30 care to Medicaid recipients and MediPass recipients.
31

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1 (32) All entities providing health care services to
2 Medicaid recipients shall make available, and encourage all
3 pregnant women and mothers with infants to receive, and
4 provide documentation in the medical records to reflect, the
5 following:
6 (a) Healthy Start prenatal or infant screening.
7 (b) Healthy Start care coordination, when screening or
8 other factors indicate need.
9 (c) Healthy Start enhanced services in accordance with
10 the prenatal or infant screening results.
11 (d) Immunizations in accordance with recommendations
12 of the Advisory Committee on Immunization Practices of the
13 United States Public Health Service and the American Academy
14 of Pediatrics, as appropriate.
15 (e) Counseling and services for family planning to all
16 women and their partners.
17 (f) A scheduled postpartum visit for the purpose of
18 voluntary family planning, to include discussion of all
19 methods of contraception, as appropriate.
20 (g) Referral to the Special Supplemental Nutrition
21 Program for Women, Infants, and Children (WIC).
22 (33) Any entity that provides Medicaid prepaid health
23 plan services shall ensure the appropriate coordination of
24 health care services with an assisted living facility in cases
25 where a Medicaid recipient is both a member of the entity's
26 prepaid health plan and a resident of the assisted living
27 facility. If the entity is at risk for Medicaid targeted case
28 management and behavioral health services, the entity shall
29 inform the assisted living facility of the procedures to
30 follow should an emergent condition arise.
31

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1 (34) The agency may seek and implement federal waivers
2 necessary to provide for cost-effective purchasing of home
3 health services, private duty nursing services,
4 transportation, independent laboratory services, and durable
5 medical equipment and supplies through competitive bidding
6 pursuant to s. 287.057. The agency may request appropriate
7 waivers from the federal Health Care Financing Administration
8 in order to competitively bid such services. The agency may
9 exclude providers not selected through the bidding process
10 from the Medicaid provider network.
11 (35) The Agency for Health Care Administration is
12 directed to issue a request for proposal or intent to
13 negotiate to implement on a demonstration basis an outpatient
14 specialty services pilot project in a rural and urban county
15 in the state. As used in this subsection, the term
16 "outpatient specialty services" means clinical laboratory,
17 diagnostic imaging, and specified home medical services to
18 include durable medical equipment, prosthetics and orthotics,
19 and infusion therapy.
20 (a) The entity that is awarded the contract to provide
21 Medicaid managed care outpatient specialty services must, at a
22 minimum, meet the following criteria:
23 1. The entity must be licensed by the Department of
24 Insurance under part II of chapter 641.
25 2. The entity must be experienced in providing
26 outpatient specialty services.
27 3. The entity must demonstrate to the satisfaction of
28 the agency that it provides high-quality services to its
29 patients.
30 4. The entity must demonstrate that it has in place a
31 complaints and grievance process to assist Medicaid recipients

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1 enrolled in the pilot managed care program to resolve
2 complaints and grievances.
3 (b) The pilot managed care program shall operate for a
4 period of 3 years. The objective of the pilot program shall
5 be to determine the cost-effectiveness and effects on
6 utilization, access, and quality of providing outpatient
7 specialty services to Medicaid recipients on a prepaid,
8 capitated basis.
9 (c) The agency shall conduct a quality assurance
10 review of the prepaid health clinic each year that the
11 demonstration program is in effect. The prepaid health clinic
12 is responsible for all expenses incurred by the agency in
13 conducting a quality assurance review.
14 (d) The entity that is awarded the contract to provide
15 outpatient specialty services to Medicaid recipients shall
16 report data required by the agency in a format specified by
17 the agency, for the purpose of conducting the evaluation
18 required in paragraph (e).
19 (e) The agency shall conduct an evaluation of the
20 pilot managed care program and report its findings to the
21 Governor and the Legislature by no later than January 1, 2001.
22 (36) The agency shall enter into agreements with
23 not-for-profit organizations based in this state for the
24 purpose of providing vision screening.
25 (37)(a) The agency shall implement a Medicaid
26 prescribed-drug spending-control program that includes the
27 following components:
28 1. Medicaid prescribed-drug coverage for brand-name
29 drugs for adult Medicaid recipients is limited to the
30 dispensing of four brand-name drugs per month per recipient.
31 Children are exempt from this restriction. Antiretroviral

1 agents are excluded from this limitation. No requirements for
2 prior authorization or other restrictions on medications used
3 to treat mental illnesses such as schizophrenia, severe
4 depression, or bipolar disorder may be imposed on Medicaid
5 recipients. Medications that will be available without
6 restriction for persons with mental illnesses include atypical
7 antipsychotic medications, conventional antipsychotic
8 medications, selective serotonin reuptake inhibitors, and
9 other medications used for the treatment of serious mental
10 illnesses. The agency shall also limit the amount of a
11 prescribed drug dispensed to no more than a 34-day supply. The
12 agency shall continue to provide unlimited generic drugs,
13 contraceptive drugs and items, and diabetic supplies. Although
14 a drug may be included on the preferred drug formulary, it
15 would not be exempt from the four-brand limit. The agency may
16 authorize exceptions to the brand-name-drug restriction based
17 upon the treatment needs of the patients, only when such
18 exceptions are based on prior consultation provided by the
19 agency or an agency contractor, but the agency must establish
20 procedures to ensure that:
21 a. There will be a response to a request for prior
22 consultation by telephone or other telecommunication device
23 within 24 hours after receipt of a request for prior
24 consultation;
25 b. A 72-hour supply of the drug prescribed will be
26 provided in an emergency or when the agency does not provide a
27 response within 24 hours as required by sub-subparagraph a.;
28 and
29 c. Except for the exception for nursing home residents
30 and other institutionalized adults and except for drugs on the
31 restricted formulary for which prior authorization may be

1 sought by an institutional or community pharmacy, prior
2 authorization for an exception to the brand-name-drug
3 restriction is sought by the prescriber and not by the
4 pharmacy. When prior authorization is granted for a patient in
5 an institutional setting beyond the brand-name-drug
6 restriction, such approval is authorized for 12 months and
7 monthly prior authorization is not required for that patient.
8 2. Reimbursement to pharmacies for Medicaid prescribed
9 drugs shall be set at the average wholesale price less 13.25
10 percent.
11 3. The agency shall develop and implement a process
12 for managing the drug therapies of Medicaid recipients who are
13 using significant numbers of prescribed drugs each month. The
14 management process may include, but is not limited to,
15 comprehensive, physician-directed medical-record reviews,
16 claims analyses, and case evaluations to determine the medical
17 necessity and appropriateness of a patient's treatment plan
18 and drug therapies. The agency may contract with a private
19 organization to provide drug-program-management services. The
20 Medicaid drug benefit management program shall include
21 initiatives to manage drug therapies for HIV/AIDS patients,
22 patients using 20 or more unique prescriptions in a 180-day
23 period, and the top 1,000 patients in annual spending.
24 4. The agency may limit the size of its pharmacy
25 network based on need, competitive bidding, price
26 negotiations, credentialing, or similar criteria. The agency
27 shall give special consideration to rural areas in determining
28 the size and location of pharmacies included in the Medicaid
29 pharmacy network. A pharmacy credentialing process may include
30 criteria such as a pharmacy's full-service status, location,
31 size, patient educational programs, patient consultation,

1 disease-management services, and other characteristics. The
2 agency may impose a moratorium on Medicaid pharmacy enrollment
3 when it is determined that it has a sufficient number of
4 Medicaid-participating providers.
5 5. The agency shall develop and implement a program
6 that requires Medicaid practitioners who prescribe drugs to
7 use a counterfeit-proof prescription pad for Medicaid
8 prescriptions. The agency shall require the use of
9 standardized counterfeit-proof prescription pads by
10 Medicaid-participating prescribers or prescribers who write
11 prescriptions for Medicaid recipients. The agency may
12 implement the program in targeted geographic areas or
13 statewide.
14 6. The agency may enter into arrangements that require
15 manufacturers of generic drugs prescribed to Medicaid
16 recipients to provide rebates of at least 15.1 percent of the
17 average manufacturer price for the manufacturer's generic
18 products. These arrangements shall require that if a
19 generic-drug manufacturer pays federal rebates for
20 Medicaid-reimbursed drugs at a level below 15.1 percent, the
21 manufacturer must provide a supplemental rebate to the state
22 in an amount necessary to achieve a 15.1-percent rebate level.
23 7. The agency may establish a preferred drug formulary
24 in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the
25 establishment of such formulary, it is authorized to negotiate
26 supplemental rebates from manufacturers that are in addition
27 to those required by Title XIX of the Social Security Act and
28 at no less than 10 percent of the average manufacturer price
29 as defined in 42 U.S.C. s. 1936 on the last day of a quarter
30 unless the federal or supplemental rebate, or both, equals or
31 exceeds 25 percent. There is no upper limit on the

1 supplemental rebates the agency may negotiate. The agency may
2 determine that specific products, brand-name or generic, are
3 competitive at lower rebate percentages. Agreement to pay the
4 minimum supplemental rebate percentage will guarantee a
5 manufacturer that the Medicaid Pharmaceutical and Therapeutics
6 Committee will consider a product for inclusion on the
7 preferred drug formulary. However, a pharmaceutical
8 manufacturer is not guaranteed placement on the formulary by
9 simply paying the minimum supplemental rebate. Agency
10 decisions will be made on the clinical efficacy of a drug and
11 recommendations of the Medicaid Pharmaceutical and
12 Therapeutics Committee, as well as the price of competing
13 products minus federal and state rebates. The agency is
14 authorized to contract with an outside agency or contractor to
15 conduct negotiations for supplemental rebates. For the
16 purposes of this section, the term "supplemental rebates" may
17 include, at the agency's discretion, cash rebates and other
18 program benefits that offset a Medicaid expenditure. Such
19 other program benefits may include, but are not limited to,
20 disease management programs, drug product donation programs,
21 drug utilization control programs, prescriber and beneficiary
22 counseling and education, fraud and abuse initiatives, and
23 other services or administrative investments with guaranteed
24 savings to the Medicaid program in the same year the rebate
25 reduction is included in the General Appropriations Act. The
26 agency is authorized to seek any federal waivers to implement
27 this initiative.
28 8. The agency shall establish an advisory committee
29 for the purposes of studying the feasibility of using a
30 restricted drug formulary for nursing home residents and other
31 institutionalized adults. The committee shall be comprised of

seven members appointed by the Secretary of Health Care Administration. The committee members shall include two physicians licensed under chapter 458 or chapter 459; three pharmacists licensed under chapter 465 and appointed from a list of recommendations provided by the Florida Long-Term Care Pharmacy Alliance; and two pharmacists licensed under chapter 465.

9. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

(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 ~~a report~~ to the Governor, the President of the Senate, and the Speaker of the House of Representatives which ~~by January 15 of each year. The report~~ must include, but need not be limited to, the progress made in implementing this subsection and its ~~Medicaid cost-containment measures and their~~ effect on Medicaid prescribed-drug expenditures.

1 (38) Notwithstanding the provisions of chapter 287,
2 the agency may, at its discretion, renew a contract or
3 contracts for fiscal intermediary services one or more times
4 for such periods as the agency may decide; however, all such
5 renewals may not combine to exceed a total period longer than
6 the term of the original contract.
7 (39) The agency shall provide for the development of a
8 demonstration project by establishment in Miami-Dade County of
9 a long-term-care facility licensed pursuant to chapter 395 to
10 improve access to health care for a predominantly minority,
11 medically underserved, and medically complex population and to
12 evaluate alternatives to nursing home care and general acute
13 care for such population. Such project is to be located in a
14 health care condominium and colocated with licensed facilities
15 providing a continuum of care. The establishment of this
16 project is not subject to the provisions of s. 408.036 or s.
17 408.039. The agency shall report its findings to the
18 Governor, the President of the Senate, and the Speaker of the
19 House of Representatives by January 1, 2003.
20 Section 6. Subsection (7) of section 409.9116, Florida
21 Statutes, is amended to read:
22 409.9116 Disproportionate share/financial assistance
23 program for rural hospitals.--In addition to the payments made
24 under s. 409.911, the Agency for Health Care Administration
25 shall administer a federally matched disproportionate share
26 program and a state-funded financial assistance program for
27 statutory rural hospitals. The agency shall make
28 disproportionate share payments to statutory rural hospitals
29 that qualify for such payments and financial assistance
30 payments to statutory rural hospitals that do not qualify for
31 disproportionate share payments. The disproportionate share

1 program payments shall be limited by and conform with federal
2 requirements. Funds shall be distributed quarterly in each
3 fiscal year for which an appropriation is made.
4 Notwithstanding the provisions of s. 409.915, counties are
5 exempt from contributing toward the cost of this special
6 reimbursement for hospitals serving a disproportionate share
7 of low-income patients.
8 (7) This section applies only to hospitals that were
9 defined as statutory rural hospitals, or their
10 successor-in-interest hospital, prior to January 1, 2001 ~~July~~
11 ~~1, 1998~~. Any additional hospital that is defined as a
12 statutory rural hospital, or its successor-in-interest
13 hospital, on or after January 1, 2001 ~~July 1, 1998~~, is not
14 eligible for programs under this section unless additional
15 funds are appropriated each fiscal year specifically to the
16 rural hospital disproportionate share and financial assistance
17 programs in an amount necessary to prevent any hospital, or
18 its successor-in-interest hospital, eligible for the programs
19 prior to January 1, 2001 ~~July 1, 1998~~, from incurring a
20 reduction in payments because of the eligibility of an
21 additional hospital to participate in the programs. A
22 hospital, or its successor-in-interest hospital, which
23 received funds pursuant to this section before January 1, 2001
24 ~~July 1, 1998~~, and which qualifies under s. 395.602(2)(e),
25 shall be included in the programs under this section and is
26 not required to seek additional appropriations under this
27 subsection.
28 Section 7. Paragraphs (f) and (k) of subsection (2) of
29 section 409.9122, Florida Statutes, as amended by section 11
30 of chapter 2001-377, Laws of Florida, are amended to read:
31

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

(2)

(f) 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 or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans ~~or provider service networks~~ until an ~~equal~~ enrollment of 45 ~~50~~ percent in MediPass and 55 ~~50~~ percent in managed care plans is achieved. Once that ~~equal~~ enrollment is achieved, the assignments shall be divided in order to maintain an ~~equal~~ enrollment in MediPass and managed care plans which is in a 45 percent and 55 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 also disproportionately assign Medicaid-eligible children in families who are required to but have failed to make a choice of managed care plan or MediPass for their child and who are to be assigned to the MediPass program or managed care plans to children's networks as described in s. 409.912(3)(g) and where available. The disproportionate assignment of children to children's networks shall be made until the agency has determined that the children's networks have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, 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.

(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 ~~equal~~ enrollment of 45 ~~50~~ percent in MediPass ~~and provider service networks~~ and 55 ~~50~~ percent in managed care plans is achieved. Once that ~~equal~~ enrollment is achieved, the assignments shall be divided in order to maintain an ~~equal~~ enrollment in

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1 MediPass and managed care plans which is in a 45 percent and
2 55 percent proportion, respectively. When making assignments,
3 the agency shall take into account the following criteria:
4 1. A managed care plan has sufficient network capacity
5 to meet the need of members.
6 2. The managed care plan or MediPass has previously
7 enrolled the recipient as a member, or one of the managed care
8 plan's primary care providers or MediPass providers has
9 previously provided health care to the recipient.
10 3. The agency has knowledge that the member has
11 previously expressed a preference for a particular managed
12 care plan or MediPass provider as indicated by Medicaid
13 fee-for-service claims data, but has failed to make a choice.
14 4. The managed care plan's or MediPass primary care
15 providers are geographically accessible to the recipient's
16 residence.
17 5. The agency has authority to make mandatory
18 assignments based on quality of service and performance of
19 managed care plans.
20 Section 8. Paragraph (a) of subsection (1) of section
21 499.012, Florida Statutes, is amended to read:
22 499.012 Wholesale distribution; definitions; permits;
23 general requirements.--
24 (1) As used in this section, the term:
25 (a) "Wholesale distribution" means distribution of
26 prescription drugs to persons other than a consumer or
27 patient, but does not include:
28 1. Any of the following activities, which is not a
29 violation of s. 499.005(21) if such activity is conducted in
30 accordance with s. 499.014:
31

1 a. The purchase or other acquisition by a hospital or
2 other health care entity that is a member of a group
3 purchasing organization of a prescription drug for its own use
4 from the group purchasing organization or from other hospitals
5 or health care entities that are members of that organization.
6 b. The sale, purchase, or trade of a prescription drug
7 or an offer to sell, purchase, or trade a prescription drug by
8 a charitable organization described in s. 501(c)(3) of the
9 Internal Revenue Code of 1986, as amended and revised, to a
10 nonprofit affiliate of the organization to the extent
11 otherwise permitted by law.
12 c. The sale, purchase, or trade of a prescription drug
13 or an offer to sell, purchase, or trade a prescription drug
14 among hospitals or other health care entities that are under
15 common control. For purposes of this section, "common control"
16 means the power to direct or cause the direction of the
17 management and policies of a person or an organization,
18 whether by ownership of stock, by voting rights, by contract,
19 or otherwise.
20 d. The sale, purchase, trade, or other transfer of a
21 prescription drug from or for any federal, state, or local
22 government agency or any entity eligible to purchase
23 prescription drugs at public health services prices pursuant
24 to Pub. L. No. 102-585, s. 602 to a contract provider or its
25 subcontractor for eligible patients of the agency or entity
26 under the following conditions:
27 (I) The agency or entity must obtain written
28 authorization for the sale, purchase, trade, or other transfer
29 of a prescription drug under this sub-subparagraph from the
30 Secretary of Health or his or her designee.
31

(II) The contract provider or subcontractor must be authorized by law to administer or dispense prescription drugs.

(III) In the case of a subcontractor, the agency or entity must be a party to and execute the subcontract.

(IV) A contract provider or subcontractor must maintain separate and apart from other prescription drug inventory any prescription drugs of the agency or entity in its possession.

(V) The contract provider and subcontractor must maintain and produce immediately for inspection all records of movement or transfer of all the prescription drugs belonging to the agency or entity, including, but not limited to, the records of receipt and disposition of prescription drugs. Each contractor and subcontractor dispensing or administering these drugs must maintain and produce records documenting the dispensing or administration. Records that are required to be maintained include, but are not limited to, a perpetual inventory itemizing drugs received and drugs dispensed by prescription number or administered by patient identifier, which must be submitted to the agency or entity quarterly.

(VI) The contract provider or subcontractor may administer or dispense the prescription drugs only to the eligible patients of the agency or entity or must return the prescription drugs for or to the agency or entity. The contract provider or subcontractor must require proof from each person seeking to fill a prescription or obtain treatment that the person is an eligible patient of the agency or entity and must, at a minimum, maintain a copy of this proof as part of the records of the contractor or subcontractor required under sub-sub-subparagraph (V).

~~(VII) The prescription drugs transferred pursuant to this sub-subparagraph may not be billed to Medicaid.~~

(VII)~~(VIII)~~ In addition to the departmental inspection authority set forth in s. 499.051, the establishment of the contract provider and subcontractor and all records pertaining to prescription drugs subject to this sub-subparagraph shall be subject to inspection by the agency or entity. All records relating to prescription drugs of a manufacturer under this sub-subparagraph shall be subject to audit by the manufacturer of those drugs, without identifying individual patient information.

2. Any of the following activities, which is not a violation of s. 499.005(21) if such activity is conducted in accordance with rules established by the department:

a. The sale, purchase, or trade of a prescription drug among federal, state, or local government health care entities that are under common control and are authorized to purchase such prescription drug.

b. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug for emergency medical reasons. For purposes of this sub-subparagraph, the term "emergency medical reasons" includes transfers of prescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage.

c. The transfer of a prescription drug acquired by a medical director on behalf of a licensed emergency medical services provider to that emergency medical services provider and its transport vehicles for use in accordance with the provider's license under chapter 401.

1 d. The revocation of a sale or the return of a
2 prescription drug to the person's prescription drug wholesale
3 supplier.
4 e. The donation of a prescription drug by a health
5 care entity to a charitable organization that has been granted
6 an exemption under s. 501(c)(3) of the Internal Revenue Code
7 of 1986, as amended, and that is authorized to possess
8 prescription drugs.
9 f. The transfer of a prescription drug by a person
10 authorized to purchase or receive prescription drugs to a
11 person licensed or permitted to handle reverse distributions
12 or destruction under the laws of the jurisdiction in which the
13 person handling the reverse distribution or destruction
14 receives the drug.
15 3. The distribution of prescription drug samples by
16 manufacturers' representatives or distributors'
17 representatives conducted in accordance with s. 499.028.
18 4. The sale, purchase, or trade of blood and blood
19 components intended for transfusion. As used in this
20 subparagraph, the term "blood" means whole blood collected
21 from a single donor and processed either for transfusion or
22 further manufacturing, and the term "blood components" means
23 that part of the blood separated by physical or mechanical
24 means.
25 5. The lawful dispensing of a prescription drug in
26 accordance with chapter 465.
27 Section 9. The Agency for Health Care Administration
28 shall conduct a study of health care services provided to the
29 medically fragile or medical-technology-dependent children in
30 the state and conduct a pilot program in Dade County to
31 provide subacute pediatric transitional care to a maximum of

1 30 children at any one time. The purposes of the study and the
2 pilot program are to determine ways to permit medically
3 fragile or medical-technology-dependent children to
4 successfully make a transition from acute care in a health
5 care institution to live with their families when possible,
6 and to provide cost-effective, subacute transitional care
7 services.
8 Section 10. The Agency for Health Care Administration,
9 in cooperation with the Children's Medical Services Program in
10 the Department of Health, shall conduct a study to identify
11 the total number of medically fragile or
12 medical-technology-dependent children, from birth through age
13 21, in the state. By January 1, 2003, the agency must report
14 to the Legislature regarding the children's ages, the
15 locations where the children are served, the types of services
16 received, itemized costs of the services, and the sources of
17 funding that pay for the services, including the proportional
18 share when more than one funding source pays for a service.
19 The study must include information regarding medically fragile
20 or medical-technology-dependent children residing in
21 hospitals, nursing homes, and medical foster care, and those
22 who live with their parents. The study must describe children
23 served in prescribed pediatric extended-care centers,
24 including their ages and the services they receive. The report
25 must identify the total services provided for each child and
26 the method for paying for those services. The report must also
27 identify the number of such children who could, if appropriate
28 transitional services were available, return home or move to a
29 less-institutional setting.
30 Section 11. (1) Within 30 days after the effective
31 date of this act, the agency shall establish minimum staffing

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1 standards and quality requirements for a subacute pediatric
2 transitional care center to be operated as a 2-year pilot
3 program in Dade County. The pilot program must operate under
4 the license of a hospital licensed under chapter 395, Florida
5 Statutes, or a nursing home licensed under chapter 400,
6 Florida Statutes, and shall use existing beds in the hospital
7 or nursing home. A child's placement in the subacute pediatric
8 transitional care center may not exceed 90 days. The center
9 shall arrange for an alternative placement at the end of a
10 child's stay and a transitional plan for children expected to
11 remain in the facility for the maximum allowed stay.
12 (2) Within 60 days after the effective date of this
13 act, the agency must amend the state Medicaid plan and request
14 any federal waivers necessary to implement and fund the pilot
15 program.
16 (3) The subacute pediatric transitional care center
17 must require level I background screening as provided in
18 chapter 435, Florida Statutes, for all employees or
19 prospective employees of the center who are expected to, or
20 whose responsibilities may require them to, provide personal
21 care or services to children, have access to children's living
22 areas, or have access to children's funds or personal
23 property.
24 Section 12. (1) The subacute pediatric transitional
25 care center must have an advisory board. Membership on the
26 advisory board must include, but need not be limited to:
27 (a) A physician and an advanced registered nurse
28 practitioner who is familiar with services for medically
29 fragile or medical-technology-dependent children;
30 (b) A registered nurse who has experience in the care
31 of medically fragile or medical-technology-dependent children;

1 (c) A child development specialist who has experience
2 in the care of medically fragile or
3 medical-technology-dependent children and their families;
4 (d) A social worker who has experience in the care of
5 medically fragile or medical-technology-dependent children and
6 their families; and
7 (e) A consumer representative who is a parent or
8 guardian of a child placed in the center.
9 (2) The advisory board shall:
10 (a) Review the policy and procedure components of the
11 center to assure conformance with applicable standards
12 developed by the Agency for Health Care Administration; and
13 (b) Provide consultation with respect to the
14 operational and programmatic components of the center.
15 Section 13. (1) The subacute pediatric transitional
16 care center must have written policies and procedures
17 governing the admission, transfer, and discharge of children.
18 (2) The admission of each child to the center must be
19 under the supervision of the center nursing administrator or
20 his or her designee, and must be in accordance with the
21 center's policies and procedures. Each Medicaid admission must
22 be approved as appropriate for placement in the facility by
23 the Children's Medical Services Multidisciplinary Assessment
24 Team of the Department of Health, in conjunction with the
25 Agency for Health Care Administration.
26 (3) Each child admitted to the center shall be
27 admitted upon prescription of the medical director of the
28 center, licensed pursuant to chapter 458 or chapter 459,
29 Florida Statutes, and the child shall remain under the care of
30 the medical director and the advanced registered nurse
31

1 practitioner for the duration of his or her stay in the
2 center.
3 (4) Each child admitted to the center must meet at
4 least the following criteria:
5 (a) The child must be medically fragile or
6 medical-technology-dependent.
7 (b) The child may not, prior to admission, present
8 significant risk of infection to other children or personnel.
9 The medical and nursing directors shall review, on a
10 case-by-case basis, the condition of any child who is
11 suspected of having an infectious disease to determine whether
12 admission is appropriate.
13 (c) The child must be medically stabilized and require
14 skilled nursing care or other interventions.
15 (5) If the child meets the criteria specified in
16 paragraphs (4)(a), (b), and (c), the medical director or
17 nursing director of the center shall implement a preadmission
18 plan that delineates services to be provided and appropriate
19 sources for such services.
20 (a) If the child is hospitalized at the time of
21 referral, preadmission planning must include the participation
22 of the child's parent or guardian and relevant medical,
23 nursing, social services, and developmental staff to assure
24 that the hospital's discharge plans will be implemented
25 following the child's placement in the center.
26 (b) A consent form, outlining the purpose of the
27 center, family responsibilities, authorized treatment,
28 appropriate release of liability, and emergency disposition
29 plans, must be signed by the parent or guardian and witnessed
30 before the child is admitted to the center. The parent or
31 guardian shall be provided a copy of the consent form.

1 Section 14. By January 1, 2003, the Agency for Health
2 Care Administration shall report to the Legislature concerning
3 the progress of the pilot program. By January 1, 2004, the
4 agency shall submit to the Legislature a report on the success
5 of the pilot program.
6 Section 15. The Office of Legislative Services shall
7 contract for a business case study of the feasibility of
8 outsourcing the administrative, investigative, legal, and
9 prosecutorial functions and other tasks and services that are
10 necessary to carry out the regulatory responsibilities of the
11 Board of Dentistry, employing its own executive director and
12 other staff, and obtaining authority over collections and
13 expenditures of funds paid by professions regulated by the
14 board into the Medical Quality Assurance Trust Fund. This
15 feasibility study must include a business plan and an
16 assessment of the direct and indirect costs associated with
17 outsourcing these functions. The sum of $50,000 is
18 appropriated from the Board of Dentistry account within the
19 Medical Quality Assurance Trust Fund to the Office of
20 Legislative Services for the purpose of contracting for the
21 study. The Office of Legislative Services shall submit the
22 completed study to the Governor, the President of the Senate,
23 and the Speaker of the House of Representatives by January 1,
24 2003.
25 Section 16. (1) Notwithstanding section 409.911,
26 Florida Statutes, for the state fiscal year 2002-2003 only,
27 the Agency for Health Care Administration shall distribute
28 moneys under the regular disproportionate share program only
29 to public hospitals. Public hospitals are defined as those
30 hospitals included in the agency's calculation of the Medicaid
31 Upper Payment Limit in accordance with 42 C.F.R. 447.272. The

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1 following methodology shall be used to distribute
2 disproportionate share dollars to the public hospitals:
3
4 For nonstate government-owned or operated hospitals:
5
6 DSHP = [(.9*HCCD)+(.1*HMD)/(CCD+TMD)]*TAAPH
7 TAAPH = TA - TAAMH
8
9 For state-owned or operated mental health hospitals:
10 DSHP = (HMD/TMHMD)*TAAMH
11
12 Where:
13 TA = total appropriation.
14 TAAPH = total amount available for public hospitals.
15 TAAMH = total amount available for mental health
16 hospitals.
17 DSHP = disproportionate share hospital payments.
18 HMD = hospital Medicaid days.
19 TMD = total state Medicaid days for public hospital.
20 HCCD = hospital charity care days.
21 TCCD = total state charity care days for public
22 hospitals.
23
24 (2) Notwithstanding section 409.9112, Florida
25 Statutes, for state fiscal year 2002-2003 only,
26 disproportionate share payments to regional perinatal
27 intensive care centers shall be equal to the disproportionate
28 payments made to the regional perinatal intensive care centers
29 in state fiscal year 2001-2002.
30 (3) Notwithstanding section 409.9117, Florida
31 Statutes, for state fiscal year 2002-2003 only,

1 disproportionate share payments to hospitals that qualify for
2 primary care disproportionate payments shall be equal to the
3 primary care disproportionate payments made to those hospitals
4 in state fiscal year 2001-2002.
5 (4) For state fiscal year 2002-2003 only, no
6 disproportionate share payments shall be made to hospitals
7 under the provisions of section 409.9119, Florida Statutes.
8 (5) In the event the Centers for Medicare and Medicaid
9 Services does not approve Florida's inpatient hospital state
10 plan amendment for the public disproportionate share program
11 by November 1, 2002, the agency may make payments to hospitals
12 under the regular disproportionate share program, regional
13 perinatal intensive care centers disproportionate share
14 program, primary care disproportionate share program, and
15 children's disproportionate share program using the same
16 methodologies used in state fiscal year 2001-2002.
17 (6) This section expires July 1, 2003.
18 Section 17. The Agency for Health Care Administration
19 may conduct a 2-year pilot project to authorize overnight
20 stays in one ambulatory surgical center located in Acute Care
21 Subdistrict 9-1. An overnight stay shall be permitted only to
22 perform plastic and reconstructive surgeries defined by
23 current procedural terminology code numbers 13000-19999. The
24 total time a patient is at the ambulatory surgical center
25 shall not exceed 23 hours and 59 minutes, including the
26 surgery time, and the maximum planned duration of all surgical
27 procedures combined shall not exceed 8 hours. Prior to
28 implementation of the pilot project, the agency shall
29 establish minimum requirements for protecting the health,
30 safety, and welfare of patients receiving overnight care.
31 These shall include, at a minimum, compliance with all

1 statutes and rules applicable to ambulatory surgical centers
2 and the requirements set forth in Rule 64B8-9.009, F.A.C.,
3 relating to Level II and Level III procedures. If the agency
4 implements the pilot project, it shall, within 6 months after
5 its completion, submit a report to the Legislature on whether
6 to expand the pilot to include all ambulatory surgical
7 centers. The recommendation shall be based on consideration of
8 the efficacy and impact to patient safety and quality of
9 patient care of providing plastic and reconstructive surgeries
10 in the ambulatory surgical center setting. The agency is
11 authorized to obtain such data as necessary to implement this
12 section.
13 Section 18. Section 624.91, Florida Statutes, is
14 amended to read:
15 624.91 The Florida Healthy Kids Corporation Act.--
16 (1) SHORT TITLE.--This section may be cited as the
17 "William G. 'Doc' Myers Healthy Kids Corporation Act."
18 (2) LEGISLATIVE INTENT.--
19 (a) The Legislature finds that increased access to
20 health care services could improve children's health and
21 reduce the incidence and costs of childhood illness and
22 disabilities among children in this state. Many children do
23 not have comprehensive, affordable health care services
24 available. It is the intent of the Legislature that the
25 Florida Healthy Kids Corporation provide comprehensive health
26 insurance coverage to such children. The corporation is
27 encouraged to cooperate with any existing health service
28 programs funded by the public or the private sector and to
29 work cooperatively with the Florida Partnership for School
30 Readiness.
31

(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act. Although the corporation may serve other children, the Legislature intends the primary recipients of services provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds, ~~to the extent permissible under federal law,~~be used to continue and expand coverage, within available appropriations, to children not eligible for federal matching funds under Title XXI ~~obtain matching federal dollars~~.

(3) NONENTITLEMENT.--Nothing in this section shall be construed as providing an individual with an entitlement to health care services. No cause of action shall arise against the state, the Florida Healthy Kids Corporation, or a unit of local government for failure to make health services available under this section.

(4) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

(a) There is created the Florida Healthy Kids Corporation, a not-for-profit corporation ~~which operates on sites designated by the corporation~~.

(b) The Florida Healthy Kids Corporation shall ~~phase in a program to~~:

1. Organize school children groups to facilitate the provision of comprehensive health insurance coverage to children;

2. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to

1 be determined by the board of directors, to provide for
2 payment of premiums for comprehensive insurance coverage and
3 for the actual or estimated administrative expenses;
4 3. Arrange for the collection of any voluntary
5 contributions to provide for payment of premiums for children
6 who are not eligible for medical assistance under Title XXI of
7 the Social Security Act. Each fiscal year, the corporation
8 shall establish a local-match policy for the enrollment of
9 non-Title XXI eligible children in the Healthy Kids program.
10 By May 1 of each year, the corporation shall provide written
11 notification of the amount to be remitted to the corporation
12 for the following fiscal year under that policy. Local-match
13 sources may include, but are not limited to, funds provided by
14 municipalities, counties, school boards, hospitals, health
15 care providers, charitable organizations, special taxing
16 districts, and private organizations. The minimum local-match
17 cash contributions required each fiscal year and local-match
18 credits shall be determined by the General Appropriations Act.
19 The corporation shall calculate a county's local-match rate
20 based upon that county's percentage of the state's total
21 non-Title XXI expenditures as reported in the corporation's
22 most recently audited financial statement. In awarding the
23 local-match credits, the corporation may consider factors
24 including, but not limited to, population density, per-capita
25 income, existing child-health-related expenditures and
26 services in awarding the credits.
27 4. Accept voluntary supplemental local-match
28 contributions that comply with the requirements of Title XXI
29 of the Social Security Act for the purpose of providing
30 additional coverage in contributing counties under Title XXI.
31

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1 5.~~3.~~ Establish the administrative and accounting
2 procedures for the operation of the corporation;
3 6.~~4.~~ Establish, with consultation from appropriate
4 professional organizations, standards for preventive health
5 services and providers and comprehensive insurance benefits
6 appropriate to children; provided that such standards for
7 rural areas shall not limit primary care providers to
8 board-certified pediatricians;
9 7.~~5.~~ Establish eligibility criteria which children
10 must meet in order to participate in the program;
11 8.~~6.~~ Establish procedures under which providers of
12 local match to,applicants to and participants in the program
13 may have grievances reviewed by an impartial body and reported
14 to the board of directors of the corporation;
15 9.~~7.~~ Establish participation criteria and, if
16 appropriate, contract with an authorized insurer, health
17 maintenance organization, or insurance administrator to
18 provide administrative services to the corporation;
19 10.~~8.~~ Establish enrollment criteria which shall
20 include penalties or waiting periods of not fewer than 60 days
21 for reinstatement of coverage upon voluntary cancellation for
22 nonpayment of family premiums;
23 11.~~9.~~ If a space is available, establish a special
24 open enrollment period of 30 days' duration for any child who
25 is enrolled in Medicaid or Medikids if such child loses
26 Medicaid or Medikids eligibility and becomes eligible for the
27 Florida Healthy Kids program;
28 12.~~10.~~ Contract with authorized insurers or any
29 provider of health care services, meeting standards
30 established by the corporation, for the provision of
31 comprehensive insurance coverage to participants. Such

standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The selection of health plans shall be based primarily on quality criteria established by the board. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded;

13. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

14.~~11.~~ Develop and implement a plan to publicize the Florida Healthy Kids Corporation, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program;

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

16.~~13.~~ As appropriate, enter into contracts with local school boards or other agencies to provide onsite information, enrollment, and other services necessary to the operation of the corporation;

17.~~14.~~ Provide a report on an annual basis to the Governor, Insurance Commissioner, Commissioner of Education, Senate President, Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives;

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18.~~15.~~ Each fiscal year, establish a maximum number of participants ~~by county~~, on a statewide basis, who may enroll in the program; and ~~without the benefit of local matching funds. Thereafter, the corporation may establish local matching requirements for supplemental participation in the program. The corporation may vary local matching requirements and enrollment by county depending on factors which may influence the generation of local match, including, but not limited to, population density, per capita income, existing local tax effort, and other factors. The corporation also may accept in-kind match in lieu of cash for the local match requirement to the extent allowed by Title XXI of the Social Security Act; and~~

19.~~16.~~ Establish eligibility criteria, premium and cost-sharing requirements, and benefit packages which conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.820.

(c) Coverage under the corporation's program is secondary to any other available private coverage held by the participant child or family member. The corporation may establish procedures for coordinating benefits under this program with benefits under other public and private coverage.

(d) The Florida Healthy Kids Corporation shall be a private corporation not for profit, organized pursuant to chapter 617, and shall have all powers necessary to carry out the purposes of this act, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this act.

1 (5) BOARD OF DIRECTORS.--
2 (a) The Florida Healthy Kids Corporation shall operate
3 subject to the supervision and approval of a board of
4 directors chaired by the Insurance Commissioner or her or his
5 designee, and composed of <u>14</u> ~~12~~ other members selected for
6 3-year terms of office as follows:
7 1. One member appointed by the Commissioner of
8 Education from among three persons nominated by the Florida
9 Association of School Administrators;
10 2. One member appointed by the Commissioner of
11 Education from among three persons nominated by the Florida
12 Association of School Boards;
13 3. One member appointed by the Commissioner of
14 Education from the Office of School Health Programs of the
15 Florida Department of Education;
16 4. One member appointed by the Governor from among
17 three members nominated by the Florida Pediatric Society;
18 5. One member, appointed by the Governor, who
19 represents the Children's Medical Services Program;
20 6. One member appointed by the Insurance Commissioner
21 from among three members nominated by the Florida Hospital
22 Association;
23 7. Two members, appointed by the Insurance
24 Commissioner, who are representatives of authorized health
25 care insurers or health maintenance organizations;
26 8. One member, appointed by the Insurance
27 Commissioner, who represents the Institute for Child Health
28 Policy;
29 9. One member, appointed by the Governor, from among
30 three members nominated by the Florida Academy of Family
31 Physicians;

1 10. One member, appointed by the Governor, who
2 represents the Agency for Health Care Administration; ~~and~~
3 11. The State Health Officer or her or his designee;~~.~~
4 12. One member, appointed by the Insurance
5 Commissioner from among three members nominated by the Florida
6 Association of Counties, representing rural counties; and
7 13. One member, appointed by the Governor from among
8 three members nominated by the Florida Association of
9 Counties, representing urban counties.
10 (b) A member of the board of directors may be removed
11 by the official who appointed that member. The board shall
12 appoint an executive director, who is responsible for other
13 staff authorized by the board.
14 (c) Board members are entitled to receive, from funds
15 of the corporation, reimbursement for per diem and travel
16 expenses as provided by s. 112.061.
17 (d) There shall be no liability on the part of, and no
18 cause of action shall arise against, any member of the board
19 of directors, or its employees or agents, for any action they
20 take in the performance of their powers and duties under this
21 act.
22 (6) LICENSING NOT REQUIRED; FISCAL OPERATION.--
23 (a) The corporation shall not be deemed an insurer.
24 The officers, directors, and employees of the corporation
25 shall not be deemed to be agents of an insurer. Neither the
26 corporation nor any officer, director, or employee of the
27 corporation is subject to the licensing requirements of the
28 insurance code or the rules of the Department of Insurance.
29 However, any marketing representative utilized and compensated
30 by the corporation must be appointed as a representative of
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1 the insurers or health services providers with which the
2 corporation contracts.
3 (b) The board has complete fiscal control over the
4 corporation and is responsible for all corporate operations.
5 (c) The Department of Insurance shall supervise any
6 liquidation or dissolution of the corporation and shall have,
7 with respect to such liquidation or dissolution, all power
8 granted to it pursuant to the insurance code.
9 (7) ACCESS TO RECORDS; CONFIDENTIALITY;
10 PENALTIES.--Notwithstanding any other laws to the contrary,
11 the Florida Healthy Kids Corporation shall have access to the
12 medical records of a student upon receipt of permission from a
13 parent or guardian of the student. Such medical records may
14 be maintained by state and local agencies. Any identifying
15 information, including medical records and family financial
16 information, obtained by the corporation pursuant to this
17 subsection is confidential and is exempt from the provisions
18 of s. 119.07(1). Neither the corporation nor the staff or
19 agents of the corporation may release, without the written
20 consent of the participant or the parent or guardian of the
21 participant, to any state or federal agency, to any private
22 business or person, or to any other entity, any confidential
23 information received pursuant to this subsection. A violation
24 of this subsection is a misdemeanor of the second degree,
25 punishable as provided in s. 775.082 or s. 775.083.
26 Section 19. This act shall take effect July 1, 2002.
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