By Senator Silver

38-1161-02

A bill to be entitled

An act relating to health care services; amending s. 215.5601, F.S., relating to the Lawton Chiles Endowment Fund; revising the amount transferred to the fund; amending s. 381.93, F.S.; revising funding requirements for the Mary Brogan Breast and Cervical Cancer Early Detection Program; revising services provided under the program; amending s. 391.021, F.S.; redefining the term "children with special health care needs" for purposes of ch. 391, F.S., relating to children's medical services; amending ss. 391.025, 391.029, F.S.; revising eligibility requirements for children's medical services; creating s. 391.309, F.S.; authorizing the Department of Health to implement the federal Individuals with Disabilities Education Act; requiring a grant application; limiting the services that may be provided without certain waivers; amending s. 404.122, F.S.; authorizing the Department of Health to use the Radiation Protection Trust Fund for additional purposes; amending s. 409.8132, F.S.; removing a requirement for choice counseling under the Medikids program; amending s. 409.814, F.S.; revising eligibility requirements for the Florida Kidcare program; amending s. 409.8177, F.S.; requiring the Agency for Health Care Administration to contract for an evaluation of the Florida Kidcare program; amending s.

409.903, F.S.; authorizing the agency to adjust fees, reimbursement rates, and services provided under Medicaid under certain circumstances; revising certain Medicaid eligibility requirements for children; authorizing certain services for noncitizens who are otherwise eligible; amending s. 409.904, F.S.; requiring premiums and copayments under the optional payment program for Medicaid-eligible persons; providing criteria for determining a person's responsibility for the cost of care; revising certain eligibility requirements for children and pregnant women; revising eligibility for certain screening services for breast and cervical cancer; revising the income limitation for certain elderly persons; amending s. 1 of ch. 2001-377, Laws of Florida, delaying the repeal of provisions that provide for optional medical assistance for certain persons; amending s. 409.908, F.S.; providing for reimbursements for Medicaid providers to be based on performance and certain other factors; amending s. 409.9117, F.S.; requiring the agency to determine a hospital's eligibility to participate in the primary care disproportionate share program; amending s. 409.912, F.S.; increasing the frequency at which the agency is required to report to the Governor and Legislature concerning its Medicaid prescribed-drug spending-control

program; amending s. 409.9122, F.S.; revising requirements for the agency with respect to assigning Medicaid recipients to a managed care plan or to MediPass; specifying those organizations, plans, or networks that qualify as a managed care plan for purposes of mandatory enrollment; repealing s. 154.02(5), F.S., relating to required reserves for county health department trust funds; providing effective dates.

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

Section 1. Subsection (3) of section 215.5601, Florida Statutes, is amended to read:

215.5601 Lawton Chiles Endowment Fund.--

(3) LAWTON CHILES ENDOWMENT FUND; CREATION; PRINCIPAL.--

(a) There is created the Lawton Chiles Endowment Fund, to be administered by the State Board of Administration. The endowment shall serve as a clearing trust fund, not subject to termination under s. 19(f), Art. III of the State Constitution. The endowment fund shall be exempt from the service charges imposed by s. 215.20.

(b) The endowment shall receive moneys from the sale of the state's right, title, and interest in and to the tobacco settlement agreement as defined in s. 215.56005, including the right to receive payments under such agreement, and from accounts transferred from the Department of Banking and Finance Tobacco Settlement Clearing Trust Fund established under s. 17.41. Amounts to be transferred from the Department

of Banking and Finance Tobacco Settlement Clearing Trust Fund to the endowment shall be in the following amounts for the following fiscal years:

1. For fiscal year 1999-2000, $1.1 billion;

2. For fiscal year 2000-2001, $200 million;

3. For fiscal year 2001-2002, $200 million; and

4. For fiscal year 2002-2003, $63.9~~$200~~ million.~~; and~~

(c) Amounts to be transferred under subparagraphs (b)2., 3., and 4. may be reduced by an amount equal to the lesser of $200 million or the amount the endowment receives in that fiscal year from the sale of the state's right, title, and interest in and to the tobacco settlement agreement.

(d) For fiscal year 2001-2002, $150 million of the existing principal in the endowment shall be reserved and accounted for within the endowment, the income from which shall be used solely for ~~the~~ funding for biomedical research activities as provided in s. 215.5602. The income from the remaining principal shall be used solely as the source of funding for health and human services programs for children and elders as provided in subsection (5). The separate account for biomedical research shall be dissolved and the entire principal in the endowment shall be used exclusively for health and human services programs when cures have been found for tobacco-related cancer, heart, and lung disease.

Section 2. Section 381.93, Florida Statutes, is amended to read:

381.93 Breast and cervical cancer early detection program.--This section may be cited as the "Mary Brogan Breast and Cervical Cancer Early Detection Program Act."

(1) It is the intent of the Legislature to reduce the rates of death due to breast and cervical cancer through early

diagnosis and increased access to early screening, diagnosis, and treatment programs.

(2) The Department of Health, pursuant to the federal Breast and Cervical Cancer Mortality Prevention Act of 1990, may ~~using available federal funds and state funds appropriated for that purpose, is authorized to~~ establish the Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program to provide screening, diagnosis, evaluation, ~~treatment,~~case management, and followup and referral to the Medicaid program ~~Agency for Health Care Administration~~ for coverage of treatment services pursuant to s. 409.904.

~~(3) The Mary Brogan Breast and Cervical Cancer Early Detection Program shall be funded through grants for such screening and early detection purposes from the federal Centers for Disease Control and Prevention under Title XV of the Public Health Service Act, 42 U.S.C. ss. 300k et seq.~~

(3)~~(4)~~ The department shall limit enrollment in the program to persons with incomes at or below ~~up to and including~~ 200 percent of the federal poverty level. The department shall establish an eligibility process that includes an income-verification process to ensure that persons served under the program meet income guidelines.

~~(5) The department may provide other breast and cervical cancer screening and diagnostic services; however, such services shall be funded separately through other sources than this act.~~

Section 3. Section 391.021, Florida Statutes, is amended to read:

391.021 Definitions.--When used in this chapter, the term ~~act, unless the context clearly indicates otherwise~~:

(1) "Children's Medical Services network" or "network" means a statewide managed care service system that includes health care providers, as defined in this section.

(2) "Children with special health care needs" means those children who have, or are at increased risk for, chronic, physical, developmental, behavioral, or emotional conditions and who also require health care and related services of a type or amount beyond that required by children generally ~~under age 21 years whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children. Health care utilization by these children exceeds the statistically expected usage of the normal child adjusted for chronological age. These children often need complex care requiring multiple providers, rehabilitation services, and specialized equipment in a number of different settings.~~

(3) "Department" means the Department of Health.

(4) "Eligible individual" means a child with a special health care need or a female with a high-risk pregnancy, who meets the financial and medical eligibility standards established in s. 391.029.

(5) "Health care provider" means a health care professional, health care facility, or entity licensed or certified to provide health services in this state that meets the criteria as established by the department.

(6) "Health services" includes the prevention, diagnosis, and treatment of human disease, pain, injury, deformity, or disabling conditions.

(7) "Participant" means an eligible individual who is enrolled in the Children's Medical Services program.

(8) "Program" means the Children's Medical Services program established in the department.

Section 4. Section 391.025, Florida Statutes, is amended to read:

391.025 Applicability and scope.--

~~(1) This act applies to health services provided to eligible individuals who are:~~

~~(a) Enrolled in the Medicaid program;~~

~~(b) Enrolled in the Florida Kidcare program; and~~

~~(c) Uninsured or underinsured, provided that they meet the financial eligibility requirements established in this act, and to the extent that resources are appropriated for their care.~~

(1)~~(2)~~ The Children's Medical Services program consists of the following components:

(a) The infant metabolic screening program established in s. 383.14.

(b) The regional perinatal intensive care centers program established in ss. 383.15-383.21.

(c) A federal or state program authorized by the Legislature.

(d) The developmental evaluation and intervention program.

(e) The Children's Medical Services network.

(2)~~(3)~~ The Children's Medical Services program shall not be deemed an insurer and is not subject to the licensing requirements of the Florida Insurance Code or the rules of the Department of Insurance, when providing services to children who receive Medicaid benefits, other Medicaid-eligible children with special health care needs, and children participating in the Florida Kidcare program.

Section 5. Section 391.029, Florida Statutes, is amended to read:

391.029 Program eligibility.--

(1) The department shall establish the medical criteria to determine if an applicant for the Children's Medical Services program is an eligible individual.

(2) The following individuals are financially eligible to receive services through ~~for~~ the program:

(a) A high-risk pregnant female who is eligible for Medicaid.

(b) A child with special health care needs from birth to age 21 years who is eligible for Medicaid.

(c) A child with special health care needs from birth to age 19 years who is eligible for a program under Title XXI of the Social Security Act.

(3) Subject to the availability of funds, the following individuals may receive services through the program:

(a)~~(d)~~ A child with special health care needs from birth to age 21 years whose family income is above the requirements for financial eligibility under Title XXI of the Social Security Act and whose projected annual cost of care adjusts the family income to Medicaid financial criteria. In cases where the family income is adjusted based on a projected annual cost of care, the family shall participate financially in the cost of care based on criteria established by the department.

(b)~~(e)~~ A child with special health care needs from birth to age 21 as provided ~~defined~~ in Title V of the Social Security Act ~~relating to children with special health care needs~~.

~~The department may continue to serve certain children with special health care needs who are 21 years of age or older and who were receiving services from the program prior to April 1, 1998. Such children may be served by the department until July 1, 2000.~~

(4)~~(3)~~ The department shall determine the financial and medical eligibility of children for the program. The department shall also determine the financial ability of the parents, or persons or other agencies having legal custody over such individuals, to pay the costs of health services under the program. The department may pay reasonable travel expenses related to the determination of eligibility for or the provision of health services.

(5)~~(4)~~ Any child who has been provided with surgical or medical care or treatment under this act prior to being adopted shall continue to be eligible to be provided with such care or treatment after his or her adoption, regardless of the financial ability of the persons adopting the child.

Section 6. Section 391.309, Florida Statutes, is created to read:

391.309 Individuals with Disabilities Education Act.--The Department of Health may implement and administer Part C of the federal Individuals with Disabilities Education Act (I.D.E.A.).

(1) The Department of Health, jointly with the Department of Education, shall annually prepare a grant application to the United States Department of Education for funding for early intervention services for infants and toddlers with disabilities, ages birth through 36 months, and

their families pursuant to Part C of the federal Individuals with Disabilities Education Act.

(2) The department shall ensure that an early intervention provider participating in the Part C program does not provide both core and required services without a waiver from the Deputy Secretary for Children's Medical Services as is expressed in the contract between the department and the provider. As used in this section, "core" services are limited to identification and referral services, family support planning, service coordination, and multidisciplinary evaluation.

Section 7. Subsection (1) of section 404.122, Florida Statutes, is amended to read:

404.122 Radiation Protection Trust Fund.--

(1) The department may use the Radiation Protection Trust Fund to pay for measures to prevent or mitigate the adverse effects from a licensee's abandonment of radioactive materials, default on lawful obligations, insolvency, ~~or~~ other inability to meet the requirements of the department or applicable state statutes or rules, or inability to pay expenses related to protection from nuclear or radiological terrorism and to assure the protection of the public health and safety and the environment from the adverse effects of ionizing radiation.

Section 8. Subsection (7) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.--

(7) ENROLLMENT.--Enrollment in the Medikids program component may only occur during periodic open enrollment periods as specified by the agency. An applicant may apply for enrollment in the Medikids program component and proceed

through the eligibility determination process at any time throughout the year. However, enrollment in Medikids shall not begin until the next open enrollment period; and a child may not receive services under the Medikids program until the child is enrolled in a managed care plan or MediPass. ~~In addition,~~Once determined eligible, an applicant may choose ~~receive choice counseling and select~~ a managed care plan or MediPass. The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's voluntary choice period ends. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients and only if the federal Health Care Financing Administration determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act.

Section 9. Section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.--A child whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. In determining the eligibility of such a child, an assets test is not required. An applicant under 19 years of age who, based on a complete application, appears to be eligible for the Medicaid component of the Florida Kidcare program is presumed eligible for coverage under Medicaid, subject to federal rules. ~~A child who has been deemed presumptively eligible for Medicaid shall not be enrolled in a managed care plan until the child's full eligibility determination for Medicaid has been completed.~~The Florida

Healthy Kids Corporation may, subject to compliance with applicable requirements of the Agency for Health Care Administration and the Department of Children and Family Services, be designated as an entity to conduct presumptive eligibility determinations. An applicant under 19 years of age who, based on a complete application, appears to be eligible for the Medikids, Florida Healthy Kids, or Children's Medical Services network program component, who is screened as ineligible for Medicaid and prior to the monthly verification of the applicant's enrollment in Medicaid or of eligibility for coverage under the state employee health benefit plan, may be enrolled in and begin receiving coverage from the appropriate program component on the first day of the month following the receipt of a completed application. For enrollment in the Children's Medical Services network, a complete application includes the medical or behavioral health screening. If, after verification, an individual is determined to be ineligible for coverage, he or she must be disenrolled from the respective Title XXI-funded Kidcare program component.

(1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be enrolled in Medicaid and is not eligible to receive health benefits under any other health benefits coverage authorized under ss. 409.810-409.820.

(2) A child who is not eligible for Medicaid, but who is eligible for the Florida Kidcare program, may obtain coverage under any of the other types of health benefits coverage authorized in ss. 409.810-409.820 if such coverage is approved and available in the county in which the child resides. However, a child who is eligible for Medikids may participate in the Florida Healthy Kids program only if the

child has a sibling participating in the Florida Healthy Kids program and the child's county of residence permits such enrollment.

(3) A child who is eligible for the Florida Kidcare program who is a child with special health care needs, as determined through a medical or behavioral screening instrument, is eligible for health benefits coverage from and shall be referred to the Children's Medical Services network.

(4) The following children are not eligible to receive premium assistance for health benefits coverage under ss. 409.810-409.820, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(a) A child who is eligible for coverage under a state health benefit plan on the basis of a family member's employment with a public agency in the state.

(b) A child who is covered under a group health benefit plan or under other health insurance coverage, excluding coverage provided under the Florida Healthy Kids Corporation as established under s. 624.91.

(c) A child who is seeking premium assistance for employer-sponsored group coverage, if the child has been covered by the same employer's group coverage during the 6 months prior to the family's submitting an application for determination of eligibility under the Florida Kidcare program.

(d) A child who is an alien, but who does not meet the definition of qualified alien, in the United States.

(e) A child who is an inmate of a public institution or a patient in an institution for mental diseases.

(5) A child whose family income is above 200 percent of the federal poverty level or a child who is excluded under the provisions of subsection (4) may participate in the Florida Healthy Kids ~~Kidcare~~ program or the Medikids program, ~~excluding the Medicaid program, but is~~ subject to the following provisions:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the premium, including any administrative costs.

(b) The agency is authorized to place limits on enrollment in Medikids by these children in order to avoid adverse selection. The number of children participating in Medikids whose family income exceeds 200 percent of the federal poverty level must not exceed 10 percent of total enrollees in the Medikids program.

(c) The board of directors of the Florida Healthy Kids Corporation is authorized to place limits on enrollment of these children in order to avoid adverse selection. In addition, the board is authorized to offer a reduced benefit package to these children in order to limit program costs for such families. The number of children participating in the Florida Healthy Kids program whose family income exceeds 200 percent of the federal poverty level must not exceed 10 percent of total enrollees in the Florida Healthy Kids program.

(d) Children described in this subsection are not counted in the annual enrollment ceiling for the Florida Kidcare program.

(6) Once a child is enrolled in the Florida Kidcare program, the child is eligible for coverage under the program for 6 months without a redetermination or reverification of

eligibility, if the family continues to pay the applicable premium. Effective January 1, 1999, a child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility.

(7) When determining or reviewing a child's eligibility under the program, the applicant shall be provided with reasonable notice of changes in eligibility which may affect enrollment in one or more of the program components. When a transition from one program component to another is appropriate, there shall be cooperation between the program components and the affected family which promotes continuity of health care coverage.

Section 10. 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.

(g)~~(7)~~ The program's choice of health benefits coverage and other methods used for providing child health assistance.

(h)~~(8)~~ The sources of nonfederal funding used in the program.

(i)~~(9)~~ An assessment of the effectiveness of Medikids, Children's Medical Services network, and other public and private programs in the state in increasing the availability of affordable quality health insurance and health care for children.

(j)~~(10)~~ A review and assessment of state activities to coordinate the program with other public and private programs.

(k)~~(11)~~ An analysis of changes and trends in the state that affect the provision of health insurance and health care to children.

(l)~~(12)~~ A description of any plans the state has for improving the availability of health insurance and health care for children.

(m)~~(13)~~ Recommendations for improving the program.

(n)~~(14)~~ Other studies as necessary.

(2) The agency shall ~~also~~ submit each month to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of enrollment for each program component of the Florida Kidcare program.

Section 11. Section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.--The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, determines to be eligible, subject to the income, assets, and ~~categorical~~ eligibility tests set forth in federal and state law. This section does not prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to conform to ~~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.

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

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

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

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

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

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

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

(5) A pregnant woman for the duration of her pregnancy and for the postpartum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level~~, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level~~. Such a person is not

subject to an assets test. ~~Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.~~

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

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

(8) A person who is age 65 or over or is determined by the agency to be disabled, whose income is at or below 100 percent of the most current federal poverty level and whose assets do not exceed limitations established by the agency.

However, the agency may only pay for premiums, coinsurance, and deductibles, as required by federal law, unless additional coverage is provided for any or all members of this group by s. 409.904(1).

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

Section 12. Section 409.904, Florida Statutes, as amended by section 2 of chapter 2001-377, Laws of Florida, is amended to read:

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

(1) A person who is age 65 or older or is determined to be disabled, whose income is at or below 90 ~~88~~ percent of federal poverty level, and whose assets do not exceed established limitations. Effective January 1, 2003, and subject to federal approval, such person shall pay a premium and copayment that may not exceed 5 percent of the person's annual income. The agency may seek and implement all waivers necessary to administer this subsection.

(2)(a) 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 person in this group, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A person in this group, which group is known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities, ~~and~~ intermediate care facilities for the developmentally disabled, and home and community-based services. Effective January 1, 2003, and subject to federal approval, such family or person shall pay a premium and copayment that may not exceed 5 percent of the family's or person's annual income. The agency may seek and implement all waivers necessary to administer this subsection. As required by federal rule, medical expenses used to spend down to the income eligibility limitations are not reimbursable under Medicaid.

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

(a) In determining the person's responsibility for the cost of care, the following amounts shall be deducted from the person's income:

1. The monthly personal-needs allowance for residents, as provided in the annual appropriations act;

2. The monthly amount, up to the current monthly Medicare Part B premium, for noncovered physician services, noncovered equipment and medical supplies, and services provided by other practitioners licensed under state law but not included as a covered benefit under the Florida Medicaid program; and

3. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

(b) Where spousal-impoverishment determinations are required by federal law, the resource-allocation limit is the maximum standard allowed by federal statute and the income allocation is the minimal amount recognized by federal statute.

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

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

(5)~~(6)~~ A child born before October 1, 1983, living in a family that has an income which is at or below 100 percent of the current federal poverty level, who has attained the age of 6, but has not attained the age of 19, and who would be eligible in s. 409.903(6), if the child had been born on or after such date. In determining the eligibility of such a child, an assets test is not required. ~~A child who is eligible for Medicaid under this subsection must be offered the opportunity, subject to federal rules, to be made presumptively eligible. A child who has been deemed presumptively eligible for Medicaid shall not be enrolled in a managed care plan until the child's full eligibility determination for Medicaid has been completed.~~

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

(7)~~(8)~~ A pregnant woman for the duration of her pregnancy and for the postpartum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income that is at or below 185 percent of the most current federal poverty level, or a child under 1 year of age who lives in a family that has an income above 185 percent of the ~~most recently published~~ federal poverty level, but which is at or below 200 percent of such poverty level. In determining the eligibility of such child, an assets test is

not required. A pregnant woman who applies for eligibility for the Medicaid program shall be offered the opportunity, subject to federal rules, to be made presumptively eligible.~~A child who is eligible for Medicaid under this subsection must be offered the opportunity, subject to federal rules, to be made presumptively eligible.~~

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

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

~~(b) A woman who has not attained 65 years of age and who has been screened for breast or cervical cancer by a qualified entity under the Mary Brogan Breast and Cervical Cancer Early Detection Program of the Department of Health and needs treatment for breast or cervical cancer and is not otherwise covered under creditable coverage, as defined in s. 2701(c) of the Public Health Service Act. For purposes of this subsection, the term "qualified entity" means a county public health department or other entity that has contracted with the Department of Health to provide breast and cervical cancer screening services paid for under this act. In determining the eligibility of such a woman, an assets test is not required. A presumptive eligibility period begins on the date on which all eligibility criteria appear to be met and ends on the date determination is made with respect to the eligibility of such woman for services under the state plan or, in the case of~~

~~such a woman who does not file an application, by the last day of the month following the month in which the presumptive eligibility determination is made. A woman is eligible until she gains creditable coverage, until treatment is no longer necessary, or until attainment of 65 years of age.~~

(10)~~(11)~~ Subject to specific federal authorization, a person who, but for earnings in excess of the limit established under s. 1905(q)(2)(B) of the Social Security Act, would be considered for receiving supplemental security income, who is at least 16 but less than 65 years of age, and whose assets, resources, and earned or unearned income, or both, do not exceed 250 percent of the most current federal poverty level. Such persons may be eligible for Medicaid services as part of a Medicaid buy-in established under s. 409.914(2) specifically designed to accommodate those persons made eligible for such a buy-in by Title II of Pub. L. No. 106-170. Such buy-in shall include income-related premiums and cost sharing.

Section 13. Effective July 1, 2003, subsections (1) and (2) of section 409.904, Florida Statutes, as amended by section 2 of chapter 2001-377, Laws of Florida, and as amended by this act, are amended to read:

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and eligibility tests set forth in federal and state law and rule. 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.

(1) A person who is age 65 or older or is determined to be disabled, whose income is at or below 88 ~~90~~ percent of federal poverty level, and whose assets do not exceed established limitations. ~~Effective January 1, 2003, and subject to federal approval,~~Such person shall pay a premium and copayment that may not exceed 5 percent of the person's annual income. The agency may seek and implement all waivers necessary to administer this subsection.

(2)(a) A pregnant woman who would otherwise qualify for Medicaid under subsection (8)~~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 person in this group, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A person in this group, which group is known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities, intermediate care facilities for the developmentally disabled, and home and community-based services. ~~Effective January 1, 2003, and subject to federal approval,~~Such ~~family or~~ person shall pay a premium and

copayment that may not exceed 5 percent of the family's or person's annual income. The agency may seek and implement all waivers necessary to administer this subsection. As required by federal rule, medical expenses used to spend down to the income eligibility limitations are not reimbursable under Medicaid.

Section 14. Section 1 of chapter 2001-377, Laws of Florida, is amended to read:

Section 1. Effective July 1, 2003 ~~2002~~, subsection (10)~~(11)~~of section 409.904, Florida Statutes, as amended by this act, is repealed.

Section 15. Subsection (15) of section 409.908, Florida Statutes, as amended by section 7 of chapter 2001-377, Laws of Florida, is amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or

making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(15) A provider of primary care case management services rendered pursuant to a federally approved waiver shall be reimbursed by payment of a ~~fixed,~~prepaid monthly sum for each Medicaid recipient enrolled with the provider. Fees may vary based on the provider's performance and an incentive system tied to the recipient's disease state, the recipient's age, and the complexity of primary case management required.

Section 16. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--

~~(1) If federal funds are available for disproportionate share programs~~ In addition to other disproportionate share programs ~~those otherwise~~ provided by law and subject to the availability of funds, there shall be created a primary care disproportionate share program. The agency shall determine the eligibility of a hospital to participate in the program.

~~(2) In the establishment and funding of this program, the agency shall use the following criteria~~ In addition to criteria ~~those~~ specified in s. 409.911, payments may not be made to a hospital unless the hospital agrees to:

(1)~~(a)~~ Cooperate with a Medicaid prepaid health plan, if one exists in the community.

(2)~~(b)~~ Ensure the availability of primary and specialty care physicians to Medicaid recipients who are not

enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

(3)~~(c)~~ Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.

(4)~~(d)~~ Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

(5)~~(e)~~ Cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

(6)~~(f)~~ In cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area.

(7)~~(g)~~ Provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay.

(8)~~(h)~~ Work with the Florida Healthy Kids Corporation, the Florida Health Care Purchasing Cooperative, and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.

(9)~~(i)~~ Work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services.

(10)~~(j)~~ Work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

Any hospital that fails to comply with any of the provisions of this section ~~subsection~~, or any other contractual condition, may not receive payments under this section until full compliance is achieved.

Section 17. 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 under 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.

(2) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients.

(3) The agency may contract with:

(a) An entity that provides no prepaid health care services other than Medicaid services under contract with the agency and which is owned and operated by a county, county health department, or county-owned and operated hospital to provide health care services on a prepaid or fixed-sum basis to recipients, which entity may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services entities must be licensed under parts I and III by January 1, 1998, and until then are exempt from the provisions of part I of chapter 641. An entity recognized under this paragraph which demonstrates to the satisfaction of the Department of Insurance that it is backed by the full faith and credit of the county in which it is located may be exempted from s. 641.225.

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

department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services. The agency may reimburse for substance-abuse-treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

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

2. By December 31, 2001, the agency shall contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Charlotte, Collier, DeSoto, Escambia, Glades, Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota, and Walton Counties. The agency may contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Alachua County. The agency may determine if Sarasota County shall be included as a separate catchment area or included in any other agency geographic area.

3. Children residing in a Department of Juvenile Justice residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan pursuant to this paragraph.

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

5. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394 and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been

obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (14) and (15).

(d) No more than four provider service networks for demonstration projects to test Medicaid direct contracting. The demonstration projects may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. A demonstration project awarded pursuant to this paragraph shall be for 4 years from the date of implementation.

(e) An entity that provides comprehensive behavioral health care services to certain Medicaid recipients through an administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that

Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services.

(f) An entity in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases in order to test the cost-effectiveness of enhanced home-based medical care. The entity providing the services shall be reimbursed on a fee-for-service basis at a rate not less than comparable Medicare reimbursement rates. The agency may apply for waivers of federal regulations necessary to implement such program. This paragraph shall be repealed on July 1, 2002.

(g) Children's provider networks that provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialty care, and other urgent and emergency care through organized providers designed to service Medicaid eligibles under age 18. The networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's networks rather than hospital emergency departments.

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

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

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

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

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

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

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

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

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

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

(b) Assumes the underwriting risk; and

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

(6) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the

exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law.

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

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

(a) Fraud;

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

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

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

(9) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(a) Prior to seeking legislative approval of such a waiver as authorized by this subsection, the agency shall provide notice and an opportunity for public comment. Notice shall be provided to all persons who have made requests of the agency for advance notice and shall be published in the Florida Administrative Weekly not less than 28 days prior to the intended action.

(b) Notwithstanding s. 216.292, funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver and are not expended shall be transferred to the agency to fund Medicaid-reimbursed nursing home care.

(10) The agency shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.

(11) The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with

public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

(12) The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.

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

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

1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review

Board shall consult with a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The panel shall begin its work by August 1, 1999, regardless of the number of appointments made by that date. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization.

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

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

4. The agency may apply for any federal waivers needed to implement this paragraph.

(14) An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency or the Department of Insurance, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues. As used in this subsection, the term "surplus" means the entity's total assets minus total liabilities. If an entity's surplus falls below an amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

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

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

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

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

(15)(a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed

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

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

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

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

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

(17) When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Department of Insurance pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger or acquisition if the contractor and the other entity have been in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase.

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

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

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

1. False or misleading claims that marketing representatives are employees or representatives of the state

or county, or of anyone other than the entity or the organization by whom they are reimbursed.

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

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

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

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (21).

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

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

(f) Enrollment of Medicaid recipients.

(19) The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect

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

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

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

(22) The agency shall utilize the statewide health maintenance organization complaint hotline for the purpose of investigating and resolving Medicaid and prepaid health plan

complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by recipients.

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

(24) The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality assurance reform initiative. The system shall include, but need not be limited to, the following:

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

1. Written quality assurance program descriptions.

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

3. An active quality assurance committee.

4. Quality assurance program supervision.

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

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

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

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

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

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

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

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

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

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

(c) Guidelines for external quality review of each contractor which require: focused studies of patterns of care; individual care review in specific situations; and followup

activities on previous pattern-of-care study findings and individual-care-review findings. In designing the external quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

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

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

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

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

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

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

(25) In order to ensure that children receive health care services for which an entity has already been compensated, an entity contracting with the agency pursuant to this section shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months. The agency shall develop a method by which the EPSDT screening rate shall be calculated. For any entity which does not achieve the annual 60 percent

rate, the entity must submit a corrective action plan for the agency's approval. If the entity does not meet the standard established in the corrective action plan during the specified timeframe, the agency is authorized to impose appropriate contract sanctions. At least annually, the agency shall publicly release the EPSDT Services screening rates of each entity it has contracted with on a prepaid basis to serve Medicaid recipients.

(26) The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (18)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and

for agency supervision and management of the managed care plan enrollment and disenrollment contract.

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

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

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

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

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

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

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

The analyses and followup activities conducted by the agency under its enhanced managed care quality assurance oversight function shall not duplicate the activities of accreditation reviewers for entities regulated under part III of chapter

641, but may include a review of the finding of such reviewers.

(29) Each managed care plan that is under contract with the agency to provide health care services to Medicaid recipients shall annually conduct a background check with the Florida Department of Law Enforcement of all persons with ownership interest of 5 percent or more or executive management responsibility for the managed care plan and shall submit to the agency information concerning any such person who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.03.

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

(31) The agency and entities which contract with the agency to provide health care services to Medicaid recipients under this section or s. 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients.

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

(a) Healthy Start prenatal or infant screening.

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

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

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

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

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

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

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

(34) The agency may seek and implement federal waivers necessary to provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, and durable medical equipment and supplies through competitive bidding pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration

in order to competitively bid such services. The agency may exclude providers not selected through the bidding process from the Medicaid provider network.

(35) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory, diagnostic imaging, and specified home medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.

(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services must, at a minimum, meet the following criteria:

1. The entity must be licensed by the Department of Insurance under part II of chapter 641.

2. The entity must be experienced in providing outpatient specialty services.

3. The entity must demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.

4. The entity must demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients enrolled in the pilot managed care program to resolve complaints and grievances.

(b) The pilot managed care program shall operate for a period of 3 years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient

specialty services to Medicaid recipients on a prepaid, capitated basis.

(c) The agency shall conduct a quality assurance review of the prepaid health clinic each year that the demonstration program is in effect. The prepaid health clinic is responsible for all expenses incurred by the agency in conducting a quality assurance review.

(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).

(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.

(36) The agency shall enter into agreements with not-for-profit organizations based in this state for the purpose of providing vision screening.

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

1. Medicaid prescribed-drug coverage for brand-name drugs for adult Medicaid recipients is limited to the dispensing of four brand-name drugs per month per recipient. Children are exempt from this restriction. Antiretroviral agents are excluded from this limitation. No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available without restriction for persons with mental illnesses include atypical

antipsychotic medications, conventional antipsychotic medications, selective serotonin reuptake inhibitors, and other medications used for the treatment of serious mental illnesses. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply. The agency shall continue to provide unlimited generic drugs, contraceptive drugs and items, and diabetic supplies. Although a drug may be included on the preferred drug formulary, it would not be exempt from the four-brand limit. The agency may authorize exceptions to the brand-name-drug restriction based upon the treatment needs of the patients, only when such exceptions are based on prior consultation provided by the agency or an agency contractor, but the agency must establish procedures to ensure that:

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

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

c. Except for the exception for nursing home residents and other institutionalized adults and except for drugs on the restricted formulary for which prior authorization may be sought by an institutional or community pharmacy, prior authorization for an exception to the brand-name-drug restriction is sought by the prescriber and not by the pharmacy. When prior authorization is granted for a patient in an institutional setting beyond the brand-name-drug

restriction, such approval is authorized for 12 months and monthly prior authorization is not required for that patient.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent.

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

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease-management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

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

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 25 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a

manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek any federal waivers to implement this initiative.

8. The agency shall establish an advisory committee for the purposes of studying the feasibility of using a restricted drug formulary for nursing home residents and other 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.

(38) Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times for such periods as the agency may decide; however, all such

renewals may not combine to exceed a total period longer than the term of the original contract.

(39) The agency shall provide for the development of a demonstration project by establishment in Miami-Dade County of a long-term-care facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and colocated with licensed facilities providing a continuum of care. The establishment of this project is not subject to the provisions of s. 408.036 or s. 408.039. The agency shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

Section 18. Subsection (2) of section 409.9122, Florida Statutes, as amended by sections 10 and 11 of chapter 2001-377, Laws of Florida, is amended to read:

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

(2)(a) The agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid recipients who are: in an institution; enrolled in the Medicaid medically needy program; or eligible for both Medicaid and Medicare. However, to the extent permitted by federal law, the agency may enroll in a managed care plan or MediPass a Medicaid recipient who is exempt from mandatory managed care enrollment, provided that:

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

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

3. The agency receives any necessary waivers from the federal Health Care Financing Administration.

The agency shall develop rules to establish policies by which exceptions to the mandatory managed care enrollment requirement may be made on a case-by-case basis. The rules shall include the specific criteria to be applied when making a determination as to whether to exempt a recipient from mandatory enrollment in a managed care plan or MediPass. School districts participating in the certified school match program pursuant to ss. 236.0812 and 409.908(21) shall be reimbursed by Medicaid, subject to the limitations of s. 236.0812(1) and (2), for a Medicaid-eligible child participating in the services as authorized in s. 236.0812, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 236.0812. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible

child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 236.0812, 381.0056, 381.0057, and 409.9071.

(b) A Medicaid recipient shall not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (3)(a) and (b), respectively.

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

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

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

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

4. Explains that recipients have the right to choose their own managed care plans or MediPass. However, if a recipient does not choose a managed care plan or MediPass, the

agency will assign the recipient to a managed care plan ~~or MediPass~~ according to the criteria specified in this section.

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

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

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 90 days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice shall be assigned to a managed care plan <u>if a managed care plan with sufficient network capacity is available in the recipient's geographic area</u> ~~or MediPass in accordance with paragraph (f)~~.

<u>1.</u> To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan ~~or MediPass~~, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency

shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan ~~or MediPass provider in accordance with paragraph (f)~~.

2. In geographic areas where the agency is contracting for the provision of comprehensive behavioral health services through a capitated, prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan.

~~(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 50 percent in MediPass and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain an equal enrollment in MediPass and managed care plans. 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 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.~~

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

(f)~~(h)~~ The agency may not engage in practices that are designed to favor one managed care plan over another or that are designed to influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass. This subsection

does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

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

recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(h)~~(j)~~ The agency shall apply for a federal waiver from the Health Care Financing Administration to lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an open enrollment period. After 12 months' enrollment, a recipient may select another managed care plan or MediPass provider. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the managed care plan or MediPass program during the 12-month period. As used in this subsection, the term "managed care plan" includes health maintenance organizations, prepaid health plans, exclusive provider organizations, provider service networks, minority physician networks, children's medical service networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act.

~~(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 50 percent in MediPass and provider service~~

~~networks and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain an equal enrollment in MediPass and managed care plans. When making assignments, the agency shall take into account the following criteria:~~

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

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

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

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

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

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

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

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

3. The percentage of voluntary disenrollments.

4. Immunization rates.

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

6. Recommendations of other authoritative bodies.

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

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

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

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

2. Credentialing standards for MediPass providers.

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

4. Immunization rates.

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

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

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

grievances which remain unresolved to the satisfaction of the enrollee.

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

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

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

(7) The agency shall investigate the feasibility of developing managed care plan and MediPass options for the following groups of Medicaid recipients:

(a) Pregnant women and infants.

(b) Elderly and disabled recipients, especially those who are at risk of nursing home placement.

(c) Persons with developmental disabilities.

(d) Qualified Medicare beneficiaries.

(e) Adults who have chronic, high-cost medical conditions.

(f) Adults and children who have mental health problems.

(g) Other recipients for whom managed care plans and MediPass offer the opportunity of more cost-effective care and greater access to qualified providers.

(8)(a) The agency shall encourage the development of public and private partnerships to foster the growth of health maintenance organizations and prepaid health plans that will provide high-quality health care to Medicaid recipients.

(b) Subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216, the agency is authorized to enter into contracts with traditional providers of health care to low-income persons to assist such providers with the technical aspects of cooperatively developing Medicaid prepaid health plans.

1. The agency may contract with disproportionate share hospitals, county health departments, federally initiated or federally funded community health centers, and counties that operate either a hospital or a community clinic.

2. A contract may not be for more than $100,000 per year, and no contract may be extended with any particular provider for more than 2 years. The contract is intended only as seed or development funding and requires a commitment from the interested party.

3. A contract must require participation by at least one community health clinic and one disproportionate share hospital.

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

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

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

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

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

(12) A managed care plan that has a Medicaid contract shall at least annually review each primary care physician's

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

Section 19. Subsection (5) of section 154.02, Florida Statutes, as created by section 3 of chapter 2001-53, Laws of Florida, is repealed.

Section 20. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2002.

****

SENATE SUMMARY

Revises various provisions governing state-funded health care services. Decreases the amount transferred to the Lawton Chiles Endowment Fund for the 2002-2003 fiscal year. Revises funding for and the services provided under the Mary Brogan Breast and Cervical Cancer Early Detection Program. Revises various eligibility requirements for certain medical services, including the Florida Kidcare program, Medicaid programs for children and pregnant women, and programs for certain elderly persons. Requires an evaluation of the Florida Kidcare program. Revises requirements for reimbursements to Medicaid providers. Revises criteria for assigning Medicaid recipients to a managed care plan or to MediPass. (See bill for details.)