By the Committee on Appropriations; and Senator Peaden

309-1949B-03

1 A bill to be entitled
2 An act relating to health care; amending s.
3 400.23, F.S.; delaying the effective date of
4 certain requirements concerning hours of direct
5 care per resident for nursing home facilities;
6 amending s. 409.904, F.S.; revising
7 requirements for certain optional payments
8 under the Medicaid program; amending s.
9 409.906, F.S.; deleting provisions authorizing
10 payment for adult dental services; revising
11 requirements for hearing and visual services to
12 limit such services to persons younger than 21
13 years of age; amending s. 409.908, F.S.,
14 relating to reimbursement of Medicaid
15 providers; conforming a cross-reference;
16 amending s. 409.9081, F.S.; providing a
17 copayment under the Medicaid program for
18 certain nonemergency hospital visits; amending
19 s. 409.912, F.S.; authorizing the Agency for
20 Health Care Administration to establish certain
21 protocols for categories of drugs; removing
22 certain requirements for prior authorization
23 for nursing home residents and
24 institutionalized adults; prohibiting
25 value-added rebates to a pharmaceutical
26 manufacturer; deleting provisions authorizing
27 certain benefits in conjunction with
28 supplemental rebates; amending s. 409.9122,
29 F.S.; revising the percentage of Medicaid
30 recipients required to be enrolled in managed
31 care; amending s. 409.915, F.S.; increasing the

requirements for county contributions to Medicaid; amending s. 409.815, F.S., relating to benefits coverage; specifying a maximum annual benefit for children's dental services; revising requirements for the Agency for Health Care Administration in distributing moneys under the regular disproportionate share program for the 2003-2004 fiscal year; providing legislative findings; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.--

(3)(a) The agency shall adopt rules providing for the minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning January 1, 2003, and increasing to 2.9 hours of direct care per resident per day beginning July ~~January~~ 1, 2004. Beginning January 1, 2002, no facility shall staff below one certified nursing assistant per 20 residents, and a minimum licensed nursing staffing of 1.0 hour of direct resident care per resident per day but never below one licensed nurse per 40 residents. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing

1 ratio for certified nursing assistants only if they provide
2 nursing assistance services to residents on a full-time basis.
3 Each nursing home must document compliance with staffing
4 standards as required under this paragraph and post daily the
5 names of staff on duty for the benefit of facility residents
6 and the public. The agency shall recognize the use of licensed
7 nurses for compliance with minimum staffing requirements for
8 certified nursing assistants, provided that the facility
9 otherwise meets the minimum staffing requirements for licensed
10 nurses and that the licensed nurses so recognized are
11 performing the duties of a certified nursing assistant. Unless
12 otherwise approved by the agency, licensed nurses counted
13 towards the minimum staffing requirements for certified
14 nursing assistants must exclusively perform the duties of a
15 certified nursing assistant for the entire shift and shall not
16 also be counted towards the minimum staffing requirements for
17 licensed nurses. If the agency approved a facility's request
18 to use a licensed nurse to perform both licensed nursing and
19 certified nursing assistant duties, the facility must allocate
20 the amount of staff time specifically spent on certified
21 nursing assistant duties for the purpose of documenting
22 compliance with minimum staffing requirements for certified
23 and licensed nursing staff. In no event may the hours of a
24 licensed nurse with dual job responsibilities be counted
25 twice.
26 Section 2. Subsection (2) of section 409.904, Florida
27 Statutes, is amended to read:
28 409.904 Optional payments for eligible persons.--The
29 agency may make payments for medical assistance and related
30 services on behalf of the following persons who are determined
31 to be eligible subject to the income, assets, and categorical

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

(2) ~~A caretaker relative or parent,~~A pregnant woman, a child under age 19 who would otherwise qualify for Florida Kidcare Medicaid, or a child up to age 21 who would otherwise qualify under s. 409.903(1), ~~a person age 65 or over, or a blind or disabled person,~~who would otherwise be eligible for Florida Medicaid, except that the income or assets of such ~~family or~~ person exceed established limitations. For a ~~family or~~ person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. Expenses used to meet spend-down liability are not reimbursable by Medicaid. Effective May 1, 2003, when determining the eligibility of a pregnant woman or~~,~~a child, ~~or an aged, blind, or disabled individual,~~$270 shall be deducted from the countable income of the filing unit. ~~When determining the eligibility of the parent or caretaker relative as defined by Title XIX of the Social Security Act, the additional income disregard of $270 does not apply.~~A ~~family or~~ person eligible under the coverage 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.

Section 3. Section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for

services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. 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 or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

~~(1) ADULT DENTAL SERVICES.--The agency may pay for medically necessary, emergency dental procedures to alleviate pain or infection. Emergency dental care shall be limited to emergency oral examinations, necessary radiographs, extractions, and incision and drainage of abscess, for a recipient who is age 21 or older. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:~~

~~(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with~~

~~Medicaid's county health department clinic services program specifications as a county health department clinic services provider.~~

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

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

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

(1)~~(2)~~ ADULT HEALTH SCREENING SERVICES.--The agency may pay for an annual routine physical examination, conducted by or under the direction of a licensed physician, for a recipient age 21 or older, without regard to medical necessity, in order to detect and prevent disease, disability, or other health condition or its progression.

(2)~~(3)~~ AMBULATORY SURGICAL CENTER SERVICES.--The agency may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395, by or under the direction of a licensed physician or dentist.

(3)~~(4)~~ BIRTH CENTER SERVICES.--The agency may pay for examinations and delivery, recovery, and newborn assessment, and related services, provided in a licensed birth center staffed with licensed physicians, certified nurse midwives, and midwives licensed in accordance with chapter 467, to a recipient expected to experience a low-risk pregnancy and delivery.

1 (4)~~(5)~~ CASE MANAGEMENT SERVICES.--The agency may pay
2 for primary care case management services rendered to a
3 recipient pursuant to a federally approved waiver, and
4 targeted case management services for specific groups of
5 targeted recipients, for which funding has been provided and
6 which are rendered pursuant to federal guidelines. The agency
7 is authorized to limit reimbursement for targeted case
8 management services in order to comply with any limitations or
9 directions provided for in the General Appropriations Act.
10 Notwithstanding s. 216.292, the Department of Children and
11 Family Services may transfer general funds to the Agency for
12 Health Care Administration to fund state match requirements
13 exceeding the amount specified in the General Appropriations
14 Act for targeted case management services.
15 (5)~~(6)~~ CHILDREN'S DENTAL SERVICES.--The agency may pay
16 for diagnostic, preventive, or corrective procedures,
17 including orthodontia in severe cases, provided to a recipient
18 under age 21, by or under the supervision of a licensed
19 dentist. Services provided under this program include
20 treatment of the teeth and associated structures of the oral
21 cavity, as well as treatment of disease, injury, or impairment
22 that may affect the oral or general health of the individual.
23 However, Medicaid will not provide reimbursement for dental
24 services provided in a mobile dental unit, except for a mobile
25 dental unit:
26 (a) Owned by, operated by, or having a contractual
27 agreement with the Department of Health and complying with
28 Medicaid's county health department clinic services program
29 specifications as a county health department clinic services
30 provider.
31

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1 (b) Owned by, operated by, or having a contractual
2 arrangement with a federally qualified health center and
3 complying with Medicaid's federally qualified health center
4 specifications as a federally qualified health center
5 provider.
6 (c) Rendering dental services to Medicaid recipients,
7 21 years of age and older, at nursing facilities.
8 (d) Owned by, operated by, or having a contractual
9 agreement with a state-approved dental educational
10 institution.
11 (6) ~~(7)~~ CHIROPRACTIC SERVICES.--The agency may pay for
12 manual manipulation of the spine and initial services,
13 screening, and X rays provided to a recipient by a licensed
14 chiropractic physician.
15 (7) ~~(8)~~ COMMUNITY MENTAL HEALTH SERVICES.--
16 (a) The agency may pay for rehabilitative services
17 provided to a recipient by a mental health or substance abuse
18 provider under contract with the agency or the Department of
19 Children and Family Services to provide such services. Those
20 services which are psychiatric in nature shall be rendered or
21 recommended by a psychiatrist, and those services which are
22 medical in nature shall be rendered or recommended by a
23 physician or psychiatrist. The agency must develop a provider
24 enrollment process for community mental health providers which
25 bases provider enrollment on an assessment of service need.
26 The provider enrollment process shall be designed to control
27 costs, prevent fraud and abuse, consider provider expertise
28 and capacity, and assess provider success in managing
29 utilization of care and measuring treatment outcomes.
30 Providers will be selected through a competitive procurement
31 or selective contracting process. In addition to other

1 community mental health providers, the agency shall consider
2 for enrollment mental health programs licensed under chapter
3 395 and group practices licensed under chapter 458, chapter
4 459, chapter 490, or chapter 491. The agency is also
5 authorized to continue operation of its behavioral health
6 utilization management program and may develop new services if
7 these actions are necessary to ensure savings from the
8 implementation of the utilization management system. The
9 agency shall coordinate the implementation of this enrollment
10 process with the Department of Children and Family Services
11 and the Department of Juvenile Justice. The agency is
12 authorized to utilize diagnostic criteria in setting
13 reimbursement rates, to preauthorize certain high-cost or
14 highly utilized services, to limit or eliminate coverage for
15 certain services, or to make any other adjustments necessary
16 to comply with any limitations or directions provided for in
17 the General Appropriations Act.
18 (b) The agency is authorized to implement
19 reimbursement and use management reforms in order to comply
20 with any limitations or directions in the General
21 Appropriations Act, which may include, but are not limited to:
22 prior authorization of treatment and service plans; prior
23 authorization of services; enhanced use review programs for
24 highly used services; and limits on services for those
25 determined to be abusing their benefit coverages.
26 (8)~~(9)~~ DIALYSIS FACILITY SERVICES.--Subject to
27 specific appropriations being provided for this purpose, the
28 agency may pay a dialysis facility that is approved as a
29 dialysis facility in accordance with Title XVIII of the Social
30 Security Act, for dialysis services that are provided to a
31 Medicaid recipient under the direction of a physician licensed

to practice medicine or osteopathic medicine in this state, including dialysis services provided in the recipient's home by a hospital-based or freestanding dialysis facility.

(9)~~(10)~~ DURABLE MEDICAL EQUIPMENT.--The agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary.

(10)~~(11)~~ HEALTHY START SERVICES.--The agency may pay for a continuum of risk-appropriate medical and psychosocial services for the Healthy Start program in accordance with a federal waiver. The agency may not implement the federal waiver unless the waiver permits the state to limit enrollment or the amount, duration, and scope of services to ensure that expenditures will not exceed funds appropriated by the Legislature or available from local sources. If the Health Care Financing Administration does not approve a federal waiver for Healthy Start services, the agency, in consultation with the Department of Health and the Florida Association of Healthy Start Coalitions, is authorized to establish a Medicaid certified-match program for Healthy Start services. Participation in the Healthy Start certified-match program shall be voluntary, and reimbursement shall be limited to the federal Medicaid share to Medicaid-enrolled Healthy Start coalitions for services provided to Medicaid recipients. The agency shall take no action to implement a certified-match program without ensuring that the amendment and review requirements of ss. 216.177 and 216.181 have been met.

(11)~~(12)~~ CHILDREN'S HEARING SERVICES.--The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient younger

than 21 years of age by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(12)~~(13)~~ HOME AND COMMUNITY-BASED SERVICES.--The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program. The agency may limit or eliminate coverage for certain Project AIDS Care Waiver services, preauthorize high-cost or highly utilized services, or make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(13)~~(14)~~ HOSPICE CARE SERVICES.--The agency may pay for all reasonable and necessary services for the palliation or management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under part VI of chapter 400 and meets Medicare certification requirements.

(14)~~(15)~~ INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED SERVICES.--The agency may pay for health-related care and services provided on a 24-hour-a-day basis by a facility licensed and certified as a Medicaid Intermediate Care Facility for the Developmentally Disabled, for a recipient who needs such care because of a developmental disability.

(15)~~(16)~~ INTERMEDIATE CARE SERVICES.--The agency may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part II of chapter 400, if the services are ordered by and provided under the direction of a physician.

(16)~~(17)~~ OPTOMETRIC SERVICES.--The agency may pay for services provided to a recipient, including examination,

1 diagnosis, treatment, and management, related to ocular
2 pathology, if the services are provided by a licensed
3 optometrist or physician.
4 (17)~~(18)~~ PHYSICIAN ASSISTANT SERVICES.--The agency may
5 pay for all services provided to a recipient by a physician
6 assistant licensed under s. 458.347 or s. 459.022.
7 Reimbursement for such services must be not less than 80
8 percent of the reimbursement that would be paid to a physician
9 who provided the same services.
10 (18)~~(19)~~ PODIATRIC SERVICES.--The agency may pay for
11 services, including diagnosis and medical, surgical,
12 palliative, and mechanical treatment, related to ailments of
13 the human foot and lower leg, if provided to a recipient by a
14 podiatric physician licensed under state law.
15 (19)~~(20)~~ PRESCRIBED DRUG SERVICES.--The agency may pay
16 for medications that are prescribed for a recipient by a
17 physician or other licensed practitioner of the healing arts
18 authorized to prescribe medications and that are dispensed to
19 the recipient by a licensed pharmacist or physician in
20 accordance with applicable state and federal law.
21 (20)~~(21)~~ REGISTERED NURSE FIRST ASSISTANT
22 SERVICES.--The agency may pay for all services provided to a
23 recipient by a registered nurse first assistant as described
24 in s. 464.027. Reimbursement for such services may not be
25 less than 80 percent of the reimbursement that would be paid
26 to a physician providing the same services.
27 (21)~~(22)~~ STATE HOSPITAL SERVICES.--The agency may pay
28 for all-inclusive psychiatric inpatient hospital care provided
29 to a recipient age 65 or older in a state mental hospital.
30 (22)~~(23)~~ CHILDREN'S VISUAL SERVICES.--The agency may
31 pay for visual examinations, eyeglasses, and eyeglass repairs

1 for a recipient younger than 21 years of age, if they are
2 prescribed by a licensed physician specializing in diseases of
3 the eye or by a licensed optometrist.
4 (23)~~(24)~~ CHILD-WELFARE-TARGETED CASE MANAGEMENT.--The
5 Agency for Health Care Administration, in consultation with
6 the Department of Children and Family Services, may establish
7 a targeted case-management project in those counties
8 identified by the Department of Children and Family Services
9 and for all counties with a community-based child welfare
10 project, as authorized under s. 409.1671, which have been
11 specifically approved by the department. Results of targeted
12 case management projects shall be reported to the Social
13 Services Estimating Conference established under s. 216.136.
14 The covered group of individuals who are eligible to receive
15 targeted case management include children who are eligible for
16 Medicaid; who are between the ages of birth through 21; and
17 who are under protective supervision or postplacement
18 supervision, under foster-care supervision, or in shelter care
19 or foster care. The number of individuals who are eligible to
20 receive targeted case management shall be limited to the
21 number for whom the Department of Children and Family Services
22 has available matching funds to cover the costs. The general
23 revenue funds required to match the funds for services
24 provided by the community-based child welfare projects are
25 limited to funds available for services described under s.
26 409.1671. The Department of Children and Family Services may
27 transfer the general revenue matching funds as billed by the
28 Agency for Health Care Administration.
29 (24)~~(25)~~ ASSISTIVE-CARE SERVICES.--The agency may pay
30 for assistive-care services provided to recipients with
31 functional or cognitive impairments residing in assisted

1 living facilities, adult family-care homes, or residential
2 treatment facilities. These services may include health
3 support, assistance with the activities of daily living and
4 the instrumental acts of daily living, assistance with
5 medication administration, and arrangements for health care.
6 Section 4. Subsection (20) of section 409.908, Florida
7 Statutes, is amended to read:
8 409.908 Reimbursement of Medicaid providers.--Subject
9 to specific appropriations, the agency shall reimburse
10 Medicaid providers, in accordance with state and federal law,
11 according to methodologies set forth in the rules of the
12 agency and in policy manuals and handbooks incorporated by
13 reference therein. These methodologies may include fee
14 schedules, reimbursement methods based on cost reporting,
15 negotiated fees, competitive bidding pursuant to s. 287.057,
16 and other mechanisms the agency considers efficient and
17 effective for purchasing services or goods on behalf of
18 recipients. If a provider is reimbursed based on cost
19 reporting and submits a cost report late and that cost report
20 would have been used to set a lower reimbursement rate for a
21 rate semester, then the provider's rate for that semester
22 shall be retroactively calculated using the new cost report,
23 and full payment at the recalculated rate shall be affected
24 retroactively. Medicare-granted extensions for filing cost
25 reports, if applicable, shall also apply to Medicaid cost
26 reports. Payment for Medicaid compensable services made on
27 behalf of Medicaid eligible persons is subject to the
28 availability of moneys and any limitations or directions
29 provided for in the General Appropriations Act or chapter 216.
30 Further, nothing in this section shall be construed to prevent
31 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.

(20) A renal dialysis facility that provides dialysis services under s. 409.906(8)~~s. 409.906(9)~~must be reimbursed the lesser of the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less.

Section 5. Subsection (1) of section 409.9081, Florida Statutes, is amended to read:

409.9081 Copayments.--

(1) The agency shall require, subject to federal regulations and limitations, each Medicaid recipient to pay at the time of service a nominal copayment for the following Medicaid services:

(a) Hospital outpatient services: up to $3 for each hospital outpatient visit.

(b) Physician services: up to $2 copayment for each visit with a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463.

(c) Hospital emergency department visits for nonemergency care: $15 for each emergency department visit.

Section 6. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall

1 maximize the use of prepaid per capita and prepaid aggregate
2 fixed-sum basis services when appropriate and other
3 alternative service delivery and reimbursement methodologies,
4 including competitive bidding pursuant to s. 287.057, designed
5 to facilitate the cost-effective purchase of a case-managed
6 continuum of care. The agency shall also require providers to
7 minimize the exposure of recipients to the need for acute
8 inpatient, custodial, and other institutional care and the
9 inappropriate or unnecessary use of high-cost services. The
10 agency may establish prior authorization requirements for
11 certain populations of Medicaid beneficiaries, certain drug
12 classes, or particular drugs to prevent fraud, abuse, overuse,
13 and possible dangerous drug interactions. The agency may also
14 establish step-therapy protocols for the categories of drugs
15 representing Cox II and proton pump inhibitor drugs.The
16 Pharmaceutical and Therapeutics Committee shall make
17 recommendations to the agency on drugs for which prior
18 authorization is required. The agency shall inform the
19 Pharmaceutical and Therapeutics Committee of its decisions
20 regarding drugs subject to prior authorization.
21 (1) The agency may enter into agreements with
22 appropriate agents of other state agencies or of any agency of
23 the Federal Government and accept such duties in respect to
24 social welfare or public aid as may be necessary to implement
25 the provisions of Title XIX of the Social Security Act and ss.
26 409.901-409.920.
27 (2) The agency may contract with health maintenance
28 organizations certified pursuant to part I of chapter 641 for
29 the provision of services to recipients.
30 (3) The agency may contract with:
31

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

1 document, the agency shall ensure that the procurement
2 document requires the contractor to develop and implement a
3 plan to ensure compliance with s. 394.4574 related to services
4 provided to residents of licensed assisted living facilities
5 that hold a limited mental health license. The agency must
6 ensure that Medicaid recipients have available the choice of
7 at least two managed care plans for their behavioral health
8 care services. To ensure unimpaired access to behavioral
9 health care services by Medicaid recipients, all contracts
10 issued pursuant to this paragraph shall require 80 percent of
11 the capitation paid to the managed care plan, including health
12 maintenance organizations, to be expended for the provision of
13 behavioral health care services. In the event the managed care
14 plan expends less than 80 percent of the capitation paid
15 pursuant to this paragraph for the provision of behavioral
16 health care services, the difference shall be returned to the
17 agency. The agency shall provide the managed care plan with a
18 certification letter indicating the amount of capitation paid
19 during each calendar year for the provision of behavioral
20 health care services pursuant to this section. The agency may
21 reimburse for substance-abuse-treatment services on a
22 fee-for-service basis until the agency finds that adequate
23 funds are available for capitated, prepaid arrangements.
24 1. By January 1, 2001, the agency shall modify the
25 contracts with the entities providing comprehensive inpatient
26 and outpatient mental health care services to Medicaid
27 recipients in Hillsborough, Highlands, Hardee, Manatee, and
28 Polk Counties, to include substance-abuse-treatment services.
29 2. By December 31, 2001, the agency shall contract
30 with entities providing comprehensive behavioral health care
31 services to Medicaid recipients through capitated, prepaid

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1 arrangements in Charlotte, Collier, DeSoto, Escambia, Glades,
2 Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota,
3 and Walton Counties. The agency may contract with entities
4 providing comprehensive behavioral health care services to
5 Medicaid recipients through capitated, prepaid arrangements in
6 Alachua County. The agency may determine if Sarasota County
7 shall be included as a separate catchment area or included in
8 any other agency geographic area.
9 3. Children residing in a Department of Juvenile
10 Justice residential program approved as a Medicaid behavioral
11 health overlay services provider shall not be included in a
12 behavioral health care prepaid health plan pursuant to this
13 paragraph.
14 4. In converting to a prepaid system of delivery, the
15 agency shall in its procurement document require an entity
16 providing comprehensive behavioral health care services to
17 prevent the displacement of indigent care patients by
18 enrollees in the Medicaid prepaid health plan providing
19 behavioral health care services from facilities receiving
20 state funding to provide indigent behavioral health care, to
21 facilities licensed under chapter 395 which do not receive
22 state funding for indigent behavioral health care, or
23 reimburse the unsubsidized facility for the cost of behavioral
24 health care provided to the displaced indigent care patient.
25 5. Traditional community mental health providers under
26 contract with the Department of Children and Family Services
27 pursuant to part IV of chapter 394 and inpatient mental health
28 providers licensed pursuant to chapter 395 must be offered an
29 opportunity to accept or decline a contract to participate in
30 any provider network for prepaid behavioral health services.
31

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1 (c) A federally qualified health center or an entity
2 owned by one or more federally qualified health centers or an
3 entity owned by other migrant and community health centers
4 receiving non-Medicaid financial support from the Federal
5 Government to provide health care services on a prepaid or
6 fixed-sum basis to recipients. Such prepaid health care
7 services entity must be licensed under parts I and III of
8 chapter 641, but shall be prohibited from serving Medicaid
9 recipients on a prepaid basis, until such licensure has been
10 obtained. However, such an entity is exempt from s. 641.225
11 if the entity meets the requirements specified in subsections
12 (14) and (15).
13 (d) No more than four provider service networks for
14 demonstration projects to test Medicaid direct contracting.
15 The demonstration projects may be reimbursed on a
16 fee-for-service or prepaid basis. A provider service network
17 which is reimbursed by the agency on a prepaid basis shall be
18 exempt from parts I and III of chapter 641, but must meet
19 appropriate financial reserve, quality assurance, and patient
20 rights requirements as established by the agency. The agency
21 shall award contracts on a competitive bid basis and shall
22 select bidders based upon price and quality of care. Medicaid
23 recipients assigned to a demonstration project shall be chosen
24 equally from those who would otherwise have been assigned to
25 prepaid plans and MediPass. The agency is authorized to seek
26 federal Medicaid waivers as necessary to implement the
27 provisions of this section. A demonstration project awarded
28 pursuant to this paragraph shall be for 4 years from the date
29 of implementation.
30 (e) An entity that provides comprehensive behavioral
31 health care services to certain Medicaid recipients through an

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1 administrative services organization agreement. Such an entity
2 must possess the clinical systems and operational competence
3 to provide comprehensive health care to Medicaid recipients.
4 As used in this paragraph, the term "comprehensive behavioral
5 health care services" means covered mental health and
6 substance abuse treatment services that are available to
7 Medicaid recipients. Any contract awarded under this paragraph
8 must be competitively procured. The agency must ensure that
9 Medicaid recipients have available the choice of at least two
10 managed care plans for their behavioral health care services.
11 (f) An entity that provides in-home physician services
12 to test the cost-effectiveness of enhanced home-based medical
13 care to Medicaid recipients with degenerative neurological
14 diseases and other diseases or disabling conditions associated
15 with high costs to Medicaid. The program shall be designed to
16 serve very disabled persons and to reduce Medicaid reimbursed
17 costs for inpatient, outpatient, and emergency department
18 services. The agency shall contract with vendors on a
19 risk-sharing basis.
20 (g) Children's provider networks that provide care
21 coordination and care management for Medicaid-eligible
22 pediatric patients, primary care, authorization of specialty
23 care, and other urgent and emergency care through organized
24 providers designed to service Medicaid eligibles under age 18
25 and pediatric emergency departments' diversion programs. The
26 networks shall provide after-hour operations, including
27 evening and weekend hours, to promote, when appropriate, the
28 use of the children's networks rather than hospital emergency
29 departments.
30 (h) An entity authorized in s. 430.205 to contract
31 with the agency and the Department of Elderly Affairs to

1 provide health care and social services on a prepaid or
2 fixed-sum basis to elderly recipients. Such prepaid health
3 care services entities are exempt from the provisions of part
4 I of chapter 641 for the first 3 years of operation. An entity
5 recognized under this paragraph that demonstrates to the
6 satisfaction of the Department of Insurance that it is backed
7 by the full faith and credit of one or more counties in which
8 it operates may be exempted from s. 641.225.
9 (i) A Children's Medical Services network, as defined
10 in s. 391.021.
11 (4) The agency may contract with any public or private
12 entity otherwise authorized by this section on a prepaid or
13 fixed-sum basis for the provision of health care services to
14 recipients. An entity may provide prepaid services to
15 recipients, either directly or through arrangements with other
16 entities, if each entity involved in providing services:
17 (a) Is organized primarily for the purpose of
18 providing health care or other services of the type regularly
19 offered to Medicaid recipients;
20 (b) Ensures that services meet the standards set by
21 the agency for quality, appropriateness, and timeliness;
22 (c) Makes provisions satisfactory to the agency for
23 insolvency protection and ensures that neither enrolled
24 Medicaid recipients nor the agency will be liable for the
25 debts of the entity;
26 (d) Submits to the agency, if a private entity, a
27 financial plan that the agency finds to be fiscally sound and
28 that provides for working capital in the form of cash or
29 equivalent liquid assets excluding revenues from Medicaid
30 premium payments equal to at least the first 3 months of
31 operating expenses or $200,000, whichever is greater;

1 (e) Furnishes evidence satisfactory to the agency of
2 adequate liability insurance coverage or an adequate plan of
3 self-insurance to respond to claims for injuries arising out
4 of the furnishing of health care;
5 (f) Provides, through contract or otherwise, for
6 periodic review of its medical facilities and services, as
7 required by the agency; and
8 (g) Provides organizational, operational, financial,
9 and other information required by the agency.
10 (5) The agency may contract on a prepaid or fixed-sum
11 basis with any health insurer that:
12 (a) Pays for health care services provided to enrolled
13 Medicaid recipients in exchange for a premium payment paid by
14 the agency;
15 (b) Assumes the underwriting risk; and
16 (c) Is organized and licensed under applicable
17 provisions of the Florida Insurance Code and is currently in
18 good standing with the Department of Insurance.
19 (6) The agency may contract on a prepaid or fixed-sum
20 basis with an exclusive provider organization to provide
21 health care services to Medicaid recipients provided that the
22 exclusive provider organization meets applicable managed care
23 plan requirements in this section, ss. 409.9122, 409.9123,
24 409.9128, and 627.6472, and other applicable provisions of
25 law.
26 (7) The Agency for Health Care Administration may
27 provide cost-effective purchasing of chiropractic services on
28 a fee-for-service basis to Medicaid recipients through
29 arrangements with a statewide chiropractic preferred provider
30 organization incorporated in this state as a not-for-profit
31 corporation. The agency shall ensure that the benefit limits

1 and prior authorization requirements in the current Medicaid
2 program shall apply to the services provided by the
3 chiropractic preferred provider organization.
4 (8) The agency shall not contract on a prepaid or
5 fixed-sum basis for Medicaid services with an entity which
6 knows or reasonably should know that any officer, director,
7 agent, managing employee, or owner of stock or beneficial
8 interest in excess of 5 percent common or preferred stock, or
9 the entity itself, has been found guilty of, regardless of
10 adjudication, or entered a plea of nolo contendere, or guilty,
11 to:
12 (a) Fraud;
13 (b) Violation of federal or state antitrust statutes,
14 including those proscribing price fixing between competitors
15 and the allocation of customers among competitors;
16 (c) Commission of a felony involving embezzlement,
17 theft, forgery, income tax evasion, bribery, falsification or
18 destruction of records, making false statements, receiving
19 stolen property, making false claims, or obstruction of
20 justice; or
21 (d) Any crime in any jurisdiction which directly
22 relates to the provision of health services on a prepaid or
23 fixed-sum basis.
24 (9) The agency, after notifying the Legislature, may
25 apply for waivers of applicable federal laws and regulations
26 as necessary to implement more appropriate systems of health
27 care for Medicaid recipients and reduce the cost of the
28 Medicaid program to the state and federal governments and
29 shall implement such programs, after legislative approval,
30 within a reasonable period of time after federal approval.
31 These programs must be designed primarily to reduce the need

1 for inpatient care, custodial care and other long-term or
2 institutional care, and other high-cost services.
3 (a) Prior to seeking legislative approval of such a
4 waiver as authorized by this subsection, the agency shall
5 provide notice and an opportunity for public comment. Notice
6 shall be provided to all persons who have made requests of the
7 agency for advance notice and shall be published in the
8 Florida Administrative Weekly not less than 28 days prior to
9 the intended action.
10 (b) Notwithstanding s. 216.292, funds that are
11 appropriated to the Department of Elderly Affairs for the
12 Assisted Living for the Elderly Medicaid waiver and are not
13 expended shall be transferred to the agency to fund
14 Medicaid-reimbursed nursing home care.
15 (10) The agency shall establish a postpayment
16 utilization control program designed to identify recipients
17 who may inappropriately overuse or underuse Medicaid services
18 and shall provide methods to correct such misuse.
19 (11) The agency shall develop and provide coordinated
20 systems of care for Medicaid recipients and may contract with
21 public or private entities to develop and administer such
22 systems of care among public and private health care providers
23 in a given geographic area.
24 (12) The agency shall operate or contract for the
25 operation of utilization management and incentive systems
26 designed to encourage cost-effective use services.
27 (13)(a) The agency shall operate the Comprehensive
28 Assessment and Review (CARES) nursing facility preadmission
29 screening program to ensure that Medicaid payment for nursing
30 facility care is made only for individuals whose conditions
31 require such care and to ensure that long-term care services

1 are provided in the setting most appropriate to the needs of
2 the person and in the most economical manner possible. The
3 CARES program shall also ensure that individuals participating
4 in Medicaid home and community-based waiver programs meet
5 criteria for those programs, consistent with approved federal
6 waivers.
7 (b) The agency shall operate the CARES program through
8 an interagency agreement with the Department of Elderly
9 Affairs.
10 (c) Prior to making payment for nursing facility
11 services for a Medicaid recipient, the agency must verify that
12 the nursing facility preadmission screening program has
13 determined that the individual requires nursing facility care
14 and that the individual cannot be safely served in
15 community-based programs. The nursing facility preadmission
16 screening program shall refer a Medicaid recipient to a
17 community-based program if the individual could be safely
18 served at a lower cost and the recipient chooses to
19 participate in such program.
20 (d) By January 1 of each year, the agency shall submit
21 a report to the Legislature and the Office of Long-Term-Care
22 Policy describing the operations of the CARES program. The
23 report must describe:
24 1. Rate of diversion to community alternative
25 programs;
26 2. CARES program staffing needs to achieve additional
27 diversions;
28 3. Reasons the program is unable to place individuals
29 in less restrictive settings when such individuals desired
30 such services and could have been served in such settings;
31

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1 4. Barriers to appropriate placement, including
2 barriers due to policies or operations of other agencies or
3 state-funded programs; and
4 5. Statutory changes necessary to ensure that
5 individuals in need of long-term care services receive care in
6 the least restrictive environment.
7 (14)(a) The agency shall identify health care
8 utilization and price patterns within the Medicaid program
9 which are not cost-effective or medically appropriate and
10 assess the effectiveness of new or alternate methods of
11 providing and monitoring service, and may implement such
12 methods as it considers appropriate. Such methods may include
13 disease management initiatives, an integrated and systematic
14 approach for managing the health care needs of recipients who
15 are at risk of or diagnosed with a specific disease by using
16 best practices, prevention strategies, clinical-practice
17 improvement, clinical interventions and protocols, outcomes
18 research, information technology, and other tools and
19 resources to reduce overall costs and improve measurable
20 outcomes.
21 (b) The responsibility of the agency under this
22 subsection shall include the development of capabilities to
23 identify actual and optimal practice patterns; patient and
24 provider educational initiatives; methods for determining
25 patient compliance with prescribed treatments; fraud, waste,
26 and abuse prevention and detection programs; and beneficiary
27 case management programs.
28 1. The practice pattern identification program shall
29 evaluate practitioner prescribing patterns based on national
30 and regional practice guidelines, comparing practitioners to
31 their peer groups. The agency and its Drug Utilization Review

1 Board shall consult with a panel of practicing health care
2 professionals consisting of the following: the Speaker of the
3 House of Representatives and the President of the Senate shall
4 each appoint three physicians licensed under chapter 458 or
5 chapter 459; and the Governor shall appoint two pharmacists
6 licensed under chapter 465 and one dentist licensed under
7 chapter 466 who is an oral surgeon. Terms of the panel members
8 shall expire at the discretion of the appointing official. The
9 panel shall begin its work by August 1, 1999, regardless of
10 the number of appointments made by that date. The advisory
11 panel shall be responsible for evaluating treatment guidelines
12 and recommending ways to incorporate their use in the practice
13 pattern identification program. Practitioners who are
14 prescribing inappropriately or inefficiently, as determined by
15 the agency, may have their prescribing of certain drugs
16 subject to prior authorization.
17 2. The agency shall also develop educational
18 interventions designed to promote the proper use of
19 medications by providers and beneficiaries.
20 3. The agency shall implement a pharmacy fraud, waste,
21 and abuse initiative that may include a surety bond or letter
22 of credit requirement for participating pharmacies, enhanced
23 provider auditing practices, the use of additional fraud and
24 abuse software, recipient management programs for
25 beneficiaries inappropriately using their benefits, and other
26 steps that will eliminate provider and recipient fraud, waste,
27 and abuse. The initiative shall address enforcement efforts to
28 reduce the number and use of counterfeit prescriptions.
29 4. By September 30, 2002, the agency shall contract
30 with an entity in the state to implement a wireless handheld
31 clinical pharmacology drug information database for

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

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

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

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

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

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

1 4. Quality assurance program supervision.
2 5. Requiring the program to have adequate resources to
3 effectively carry out its specified activities.
4 6. Provider participation in the quality assurance
5 program.
6 7. Delegation of quality assurance program activities.
7 8. Credentialing and recredentialing.
8 9. Enrollee rights and responsibilities.
9 10. Availability and accessibility to services and
10 care.
11 11. Ambulatory care facilities.
12 12. Accessibility and availability of medical records,
13 as well as proper recordkeeping and process for record review.
14 13. Utilization review.
15 14. A continuity of care system.
16 15. Quality assurance program documentation.
17 16. Coordination of quality assurance activity with
18 other management activity.
19 17. Delivering care to pregnant women and infants; to
20 elderly and disabled recipients, especially those who are at
21 risk of institutional placement; to persons with developmental
22 disabilities; and to adults who have chronic, high-cost
23 medical conditions.
24 (b) Guidelines which require the entities to conduct
25 quality-of-care studies which:
26 1. Target specific conditions and specific health
27 service delivery issues for focused monitoring and evaluation.
28 2. Use clinical care standards or practice guidelines
29 to objectively evaluate the care the entity delivers or fails
30 to deliver for the targeted clinical conditions and health
31 services delivery issues.

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

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

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

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

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

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

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

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

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

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

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1 supplemental rebates the agency may negotiate. The agency may
2 determine that specific products, brand-name or generic, are
3 competitive at lower rebate percentages. Agreement to pay the
4 minimum supplemental rebate percentage will guarantee a
5 manufacturer that the Medicaid Pharmaceutical and Therapeutics
6 Committee will consider a product for inclusion on the
7 preferred drug formulary. However, a pharmaceutical
8 manufacturer is not guaranteed placement on the formulary by
9 simply paying the minimum supplemental rebate. Agency
10 decisions will be made on the clinical efficacy of a drug and
11 recommendations of the Medicaid Pharmaceutical and
12 Therapeutics Committee, as well as the price of competing
13 products minus federal and state rebates. The agency is
14 authorized to contract with an outside agency or contractor to
15 conduct negotiations for supplemental rebates. For the
16 purposes of this section, the term "supplemental rebates" may
17 include, at the agency's discretion, cash rebates and other
18 program benefits that offset a Medicaid expenditure. <u>Effective</u>
19 <u>July 1, 2003, value-added programs as a substitution for</u>
20 <u>supplemental rebates are prohibited.</u>~~Such other program~~
21 ~~benefits may include, but are not limited to, disease~~
22 ~~management programs, drug product donation programs, drug~~
23 ~~utilization control programs, prescriber and beneficiary~~
24 ~~counseling and education, fraud and abuse initiatives, and~~
25 ~~other services or administrative investments with guaranteed~~
26 ~~savings to the Medicaid program in the same year the rebate~~
27 ~~reduction is included in the General Appropriations Act.~~The
28 agency is authorized to seek any federal waivers to implement
29 this initiative.
30 8. The agency shall establish an advisory committee
31 for the purposes of studying the feasibility of using a

1 restricted drug formulary for nursing home residents and other
2 institutionalized adults. The committee shall be comprised of
3 seven members appointed by the Secretary of Health Care
4 Administration. The committee members shall include two
5 physicians licensed under chapter 458 or chapter 459; three
6 pharmacists licensed under chapter 465 and appointed from a
7 list of recommendations provided by the Florida Long-Term Care
8 Pharmacy Alliance; and two pharmacists licensed under chapter
9 465.
10 9. The Agency for Health Care Administration shall
11 expand home delivery of pharmacy products. To assist Medicaid
12 patients in securing their prescriptions and reduce program
13 costs, the agency shall expand its current mail-order-pharmacy
14 diabetes-supply program to include all generic and brand-name
15 drugs used by Medicaid patients with diabetes. Medicaid
16 recipients in the current program may obtain nondiabetes drugs
17 on a voluntary basis. This initiative is limited to the
18 geographic area covered by the current contract. The agency
19 may seek and implement any federal waivers necessary to
20 implement this subparagraph.
21 (b) The agency shall implement this subsection to the
22 extent that funds are appropriated to administer the Medicaid
23 prescribed-drug spending-control program. The agency may
24 contract all or any part of this program to private
25 organizations.
26 (c) The agency shall submit quarterly reports to the
27 Governor, the President of the Senate, and the Speaker of the
28 House of Representatives which must include, but need not be
29 limited to, the progress made in implementing this subsection
30 and its effect on Medicaid prescribed-drug expenditures.
31

(39) 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.

(40) 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 7. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 ~~45~~ percent in MediPass and 60 ~~55~~ percent in managed care plans is

1 achieved. Once this enrollment is achieved, the assignments
2 shall be divided in order to maintain an enrollment in
3 MediPass and managed care plans which is in a 40 ~~45~~ percent
4 and 60 ~~55~~ percent proportion, respectively. Thereafter,
5 assignment of Medicaid recipients who fail to make a choice
6 shall be based proportionally on the preferences of recipients
7 who have made a choice in the previous period. Such
8 proportions shall be revised at least quarterly to reflect an
9 update of the preferences of Medicaid recipients. The agency
10 shall disproportionately assign Medicaid-eligible recipients
11 who are required to but have failed to make a choice of
12 managed care plan or MediPass, including children, and who are
13 to be assigned to the MediPass program to children's networks
14 as described in s. 409.912(3)(g), Children's Medical Services
15 network as defined in s. 391.021, exclusive provider
16 organizations, provider service networks, minority physician
17 networks, and pediatric emergency department diversion
18 programs authorized by this chapter or the General
19 Appropriations Act, in such manner as the agency deems
20 appropriate, until the agency has determined that the networks
21 and programs have sufficient numbers to be economically
22 operated. For purposes of this paragraph, when referring to
23 assignment, the term "managed care plans" includes health
24 maintenance organizations, exclusive provider organizations,
25 provider service networks, minority physician networks,
26 Children's Medical Services network, and pediatric emergency
27 department diversion programs authorized by this chapter or
28 the General Appropriations Act. Beginning July 1, 2002, the
29 agency shall assign all children in families who have not made
30 a choice of a managed care plan or MediPass in the required
31 timeframe to a pediatric emergency room diversion program

1 described in s. 409.912(3)(g) that, as of July 1, 2002, has
2 executed a contract with the agency, until such network or
3 program has reached an enrollment of 15,000 children. Once
4 that minimum enrollment level has been reached, the agency
5 shall assign children who have not chosen a managed care plan
6 or MediPass to the network or program in a manner that
7 maintains the minimum enrollment in the network or program at
8 not less than 15,000 children. To the extent practicable, the
9 agency shall also assign all eligible children in the same
10 family to such network or program. When making assignments,
11 the agency shall take into account the following criteria:
12 1. A managed care plan has sufficient network capacity
13 to meet the need of members.
14 2. The managed care plan or MediPass has previously
15 enrolled the recipient as a member, or one of the managed care
16 plan's primary care providers or MediPass providers has
17 previously provided health care to the recipient.
18 3. The agency has knowledge that the member has
19 previously expressed a preference for a particular managed
20 care plan or MediPass provider as indicated by Medicaid
21 fee-for-service claims data, but has failed to make a choice.
22 4. The managed care plan's or MediPass primary care
23 providers are geographically accessible to the recipient's
24 residence.
25 (k) When a Medicaid recipient does not choose a
26 managed care plan or MediPass provider, the agency shall
27 assign the Medicaid recipient to a managed care plan, except
28 in those counties in which there are fewer than two managed
29 care plans accepting Medicaid enrollees, in which case
30 assignment shall be to a managed care plan or a MediPass
31 provider. Medicaid recipients in counties with fewer than two

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managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 ~~45~~ percent in MediPass and 60 ~~55~~ percent in managed care plans is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 40 ~~45~~ percent and 60 ~~55~~ percent proportion, respectively. 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. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

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

Section 8. Subsection (2) of section 409.915, Florida Statutes, is amended to read:

409.915 County contributions to Medicaid.--Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

(2) A county's participation must be 35 percent of the total cost, or the applicable discounted cost paid by the state for Medicaid recipients enrolled in health maintenance organizations or prepaid health plans, of providing the items listed in subsection (1), except that the payments for items listed in paragraph (1)(b) may not exceed $70 ~~$55~~ per month per person.

Section 9. Paragraph (q) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.--

(2) BENCHMARK BENEFITS.--In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

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(q) Dental services.--~~Subject to a specific appropriation for this benefit,~~Covered services include those dental services provided to children by the Florida Medicaid program under s. 409.906(5), up to a maximum benefit of $750 per enrollee per year.

Section 10. (1) Notwithstanding section 409.911(3), Florida Statutes, for the state fiscal year 2003-2004 only, the agency shall distribute moneys under the regular disproportionate share program only to hospitals that meet the federal minimum requirements and to public hospitals. Public hospitals are defined as those hospitals identified as government owned or operated in the Financial Hospital Uniform Reporting System (FHURS) data available to the agency as of January 1, 2002. The following methodology shall be used to distribute disproportionate share dollars to hospitals that meet the federal minimum requirements and to the public hospitals:

(a) For hospitals that meet the federal minimum requirements and do not qualify as a public hospital, the following formula shall be used:

DSHP = (HMD/TMSD)*$1 million

DSHP = disproportionate share hospital payment.
HMD = hospital Medicaid days.
TSD = total state Medicaid days.

(b) The following formulas shall be used to pay disproportionate share dollars to public hospitals:

1. For state mental health hospitals:

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1 DSHP = (HMD/TMDMH) * TAAMH
2
3 The total amount available for the state mental health
4 hospitals shall be the difference between the federal cap for
5 Institutions for Mental Diseases and the amounts paid under
6 the mental health disproportionate share program.
7 2. For non-state government owned or operated
8 hospitals with 3,200 or more Medicaid days:
9
10 DSHP = [(.82*HCCD/TCCD) + (.18*HMD/TMD)] * TAAPH
11 TAAPH = TAA - TAAMH
12
13 3. For non-state government owned or operated
14 hospitals with less than 3,200 Medicaid days, a total of
15 $400,000 shall be distributed equally among these hospitals.
16
17 Where:
18
19 TAA = total available appropriation.
20 TAAPH = total amount available for public hospitals.
21 TAAMH = total amount available for mental health hospitals.
22 DSHP = disproportionate share hospital payments.
23 HMD = hospital Medicaid days.
24 TMDMH = total state Medicaid days for mental health days.
25 TMD = total state Medicaid days for public hospitals.
26 HCCD = hospital charity care dollars.
27 TCCD = total state charity care dollars for public non-state
28 hospitals.
29
30 In computing the above amounts for public hospitals and
31 hospitals that qualify under the federal minimum requirements,

1 the agency shall use the 1997 audited data. In the event there
2 is no complete 1997 audited data for a hospital, the agency
3 shall use the 1994 audited data.
4 (2) Notwithstanding section 409.9112, Florida
5 Statutes, for state fiscal year 2003-2004, only
6 disproportionate share payments to regional perinatal
7 intensive care centers shall be distributed in the same
8 proportion as the disproportionate share payments made to the
9 regional perinatal intensive care centers in the state fiscal
10 year 2001-2002.
11 (3) Notwithstanding section 409.9117, Florida
12 Statutes, for state fiscal year 2003-2004 only,
13 disproportionate share payments to hospitals that qualify for
14 primary care disproportionate share payments shall be
15 distributed in the same proportion as the primary care
16 disproportionate share payments made to those hospitals in the
17 state fiscal year 2001-2002.
18 (4) For state fiscal year 2003-2004 only, no
19 disproportionate share payments for specialty hospitals for
20 children shall be made to hospitals under the provisions of
21 section 409.9119, Florida Statutes.
22 (5) This section is repealed on July 1, 2004.
23 Section 11. The Legislature finds and declares that
24 this act fulfills an important state interest.
25 Section 12. This act shall take effect July 1, 2003.
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STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 390

1. Delays the certified nursing assistant staffing increase of 2.9 hours of direct care per resident per day from January 1, 2004 to July 1, 2004;

2. Eliminates Medicaid coverage of Adults (with the exception of pregnant women) under the Medically Needy Program effective July 1, 2003;

3. Eliminates Medicaid coverage of Adult Dental, Visual and Hearing Services effective July 1, 2003;

4. Requires Medicaid recipients to pay a $15 co-payment for non-emergency use of a hospital emergency department;

5. Allows the establishment of step therapy protocols in Medicaid for the categories of drugs representing Cox II and proton pump inhibitor drugs;

6. Requires the prescriber (not the long-term care pharmacy) to request an exception to the limit of four-brand drugs for Medicaid nursing home residents and other institutionalized adults;

7. Eliminates value-added agreements with pharmaceutical manufacturers in lieu of supplemental rebates in the Medicaid program as of July 1, 2003;

8. Revises the Medicaid program enrollment goal for managed care to 60 percent managed care and 40 percent MediPass;

9. Increases county contributions related to Medicaid-funded nursing home services from a cap of $55 per person per month to $70;

10. Implements a maximum annual dental benefit of $750 per enrollee in the Florida Healthy Kids program;

11. Continues changes made in FY 2002-03 that revise the Medicaid regular disproportionate share hospital (DSH) program formula to include only public hospitals and provide guidelines to distribute disproportionate share funds under the regular program, the regional perinatal intensive care center program, the primary care program and the children's specialty hospital program; and

12. Contains a statement that the Legislature finds and declares that this act fulfills an important state interest.

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