CONFERENCE COMMITTEE AMENDMENT

Bill No. HB 1843

Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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The Conference Committee on HB 1843 offered the following:

Conference Committee Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Effective upon this act becoming a law and applying retroactively to May 1, 2004, 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 ~~May~~ 1, 2005 ~~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 never below one licensed nurse per 40 residents. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants only if they provide nursing assistance services to residents on a full-time basis. Each nursing home must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses so recognized are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted towards the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and shall not also be counted towards the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically

spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

Section 2. Paragraphs (c) and (d) of subsection (5) of section 408.909, Florida Statutes, are redesignated as paragraphs (d) and (e), respectively, present paragraph (c) of subsection (5) of said section is amended, and a new paragraph (c) is added to said subsection, to read:

408.909 Health flex plans.--

(5) ELIGIBILITY.--Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(c) Are eligible under a federally approved Medicaid demonstration waiver and reside in Palm Beach County or Miami-Dade County;

(d)~~(c)~~ Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, unless specifically authorized under paragraph (c), or another public health care program, such as KidCare, and have not been covered at any time during the past 6 months; and

Section 3. Subsection (2) of section 409.8134, Florida Statutes, as amended by chapter 2004-1, Laws of Florida, is amended to read:

409.8134 Program enrollment and expenditure ceilings.--

(2) Upon a unanimous recommendation by representatives from each of the four Florida KidCare administrators, the

Florida KidCare program may conduct an open enrollment period for the purpose of enrolling children eligible for all program components listed in s. 409.813 except Medicaid. The four Florida KidCare administrators shall work together to ensure that the open enrollment period is announced statewide at least 1 month before the open enrollment is to begin. Eligible children shall be enrolled on a first-come, first-served basis using the date the open enrollment application is received. The potential open enrollment periods shall be January 1st through January 30th and September 1st through September 30th. Open enrollment shall immediately cease when the enrollment ceiling is reached ~~reaches~~. An open enrollment shall only be held if the Social Services Estimating Conference determines that sufficient federal and state funds will be available to finance the increased enrollment through federal fiscal year 2007. Any individual who is not enrolled, including those added to the waiting list after March 11 ~~January 30~~, 2004, must reapply by submitting a new application during the next open enrollment period. However, the Children's Medical Services Network may annually enroll up to 120 additional children based on emergency disability criteria outside of the open enrollment periods and the cost of serving these children must be managed within the KidCare program's appropriated or authorized levels of funding. Except for the Medicaid program, whenever the Social Services Estimating Conference determines that there is presently, or will be by the end of the current fiscal year, insufficient funds to finance the current or projected enrollment in the Florida KidCare program, all additional enrollment must cease

and additional enrollment may not resume until sufficient funds are available to finance such enrollment.

Section 4. Paragraph (f) of subsection (4) and paragraph (a) of subsection (8) of section 409.814, Florida Statutes, as amended by chapter 2004-1, Laws of Florida, are amended, and paragraph (g) is added to subsection (4) of said section, to read:

409.814 Eligibility.--A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida KidCare program as provided in this section. For enrollment in the Children's Medical Services network, a complete application includes the medical or behavioral health screening. If, subsequently, an individual is determined to be ineligible for coverage, he or she must immediately be disenrolled from the respective Florida KidCare program component.

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

(f) A child who has had his or her coverage in an employer-sponsored health benefit plan voluntarily canceled in the last 6 months, except those children who were on the waiting list prior to March 12 ~~January 31~~, 2004.

(g) A child who is otherwise eligible for KidCare and who has a preexisting condition that prevents coverage under another

insurance plan as described in paragraph (b) which would have disqualified the child for KidCare if the child were able to enroll in the plan shall be eligible for KidCare coverage when enrollment is possible.

(8) In determining the eligibility of a child, an assets test is not required. Each applicant shall provide written documentation during the application process and the redetermination process, including, but not limited to, the following:

(a) Proof of family income supported by copies of any federal income tax return for the prior year, any wages and earnings statements (W-2 forms), and any other appropriate document.

Section 5. Effective January 1, 2005, subsection (6) of section 409.814, Florida Statutes, as amended by chapter 2004-1, Laws of Florida, is amended to read:

409.814 Eligibility.--A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida KidCare program as provided in this section. For enrollment in the Children's Medical Services network, a complete application includes the medical or behavioral health screening. If, subsequently, an individual is determined to be ineligible for coverage, he or she must immediately be disenrolled from the respective Florida KidCare program component.

(6) Once a child is enrolled in the Florida KidCare program, the child is eligible for coverage under the program for 12 ~~6~~ months without a redetermination or reverification of

eligibility, if the family continues to pay the applicable premium. Eligibility for program components funded through Title XXI of the Social Security Act shall terminate when a child attains the age of 19. Effective January 1, 1999, a child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility.

Section 6. Subsection (5) of section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.--The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. 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.

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

the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program. Effective July 1, 2005, eligibility for Medicaid services is eliminated for women who have incomes above 150 percent of the most current federal poverty level.

Section 7. Subsections (2) and (3) of section 409.904, Florida Statutes, are amended to read:

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and 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 family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), 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. 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.

Effective July 1, 2005, the medically needy are eligible for prescribed drug services only.

(3) A person who is in need of the services of a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, or a state mental hospital, whose income does not exceed 300 percent of the SSI income standard, and who meets the assets standards established under federal and state law. In determining the person's responsibility for the cost of care, the following amounts must be deducted from the person's income:

(a) The monthly personal allowance for residents as set based on appropriations.

(b) The reasonable costs of medically necessary services and supplies that are not reimbursable by the Medicaid program.

(c) The cost of premiums, copayments, coinsurance, and deductibles for supplemental health insurance.

Section 8. Subsections (4), (5), and (8) of section 409.905, Florida Statutes, are amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted 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, number of services, or 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.

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection shall be licensed under part IV of chapter 400 ~~or part II of chapter 499, if appropriate~~. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(a) In providing home health care services, the agency may require prior authorization of care based on diagnosis.

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule

regarding work, school, sleep, and care for other family dependents. When implemented, the private duty nursing utilization management program shall replace the current authorization program used by the Agency for Health Care Administration and the Children's Medical Services program of the Department of Health. The agency may competitively bid on a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency is authorized to seek federal waivers to implement this initiative.

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service;

adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program.

(b) A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Medicaid program except as provided in federal law. However, the department shall apply for a waiver, within 9 months after June 5, 1991, designed to provide hospitalization services for mental health reasons to children and adults in the most cost-effective and lowest cost setting possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The waiver

proposal shall propose no additional aggregate cost to the state or Federal Government, and shall be conducted in Hillsborough County, Highlands County, Hardee County, Manatee County, and Polk County. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to ensure the earliest discharge possible, and the comprehensiveness of the mental health and other health care services offered by participating providers.

(c) The Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995;

2. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or

3. The hospital is located in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital's Medicaid

inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.

No later than October 1 of each year, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the General Appropriations Act to support the increase in cost as estimated by the agency.

(d) The agency shall implement a hospitalist program in certain high-volume participating hospitals, select counties, or statewide. The program shall require hospitalists to authorize and manage Medicaid recipients' hospital admissions and lengths of stay. Individuals who are dually eligible for Medicare and Medicaid are exempted from this requirement. Medicaid participating physicians and other practitioners with hospital admitting privileges shall coordinate and review admissions of Medicaid recipients with the hospitalist. The agency may competitively bid a contract for selection of a qualified organization to provide hospitalist services. The qualified organization shall employ board certified physicians who are full-time dedicated employees of the contractor and have no outside practice. Where used, the hospitalist program shall replace the existing hospital utilization review program. The

agency is authorized to seek federal waivers to implement this program.

(e) The agency shall implement a comprehensive utilization management program for hospital neonatal intensive care stays in certain high-volume participating hospitals, select counties, or statewide, and shall replace existing hospital inpatient utilization management programs for neonatal intensive care admissions. The program shall be designed to manage the lengths of stay for children being treated in neonatal intensive care units and must seek the earliest medically appropriate discharge to the child's home or other less costly treatment setting. The agency may competitively bid a contract for selection of a qualified organization to provide neonatal intensive care utilization management services. The agency is authorized to seek any federal waivers to implement this initiative.

(8) NURSING FACILITY SERVICES.--The agency shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined by s. 395.002(11), that is licensed under part I of chapter 395, and in accordance with provisions set forth in s. 409.908(2)(a), which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the agency must pay for similar services temporarily in a hospital licensed under part I

of chapter 395 provided federal funding is approved and available. The agency shall pay only for bed hold days if the facility has an occupancy rate of 95 percent or greater. The agency is authorized to seek any federal waivers to implement this policy.

Section 9. Subsections (1), (13), and (15) of section 409.906, Florida Statutes, are 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.--

(a) 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 years of age or older.

(b) Beginning January 1, 2005, the agency may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is 21 years of age or older. This paragraph is repealed effective July 1, 2005.

(c) However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

1.~~(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.

2.~~(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.

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

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

(13) HOME AND COMMUNITY-BASED SERVICES.--

(a) 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.

(b) The agency may consolidate types of services offered in the Aged and Disabled Waiver, the Channeling Waiver, the Project AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury Waiver programs in order to group similar services under a single service, or continue a service upon evidence of the need for including a particular service type in a particular waiver. The agency is authorized to seek a Medicaid state plan amendment or federal waiver approval to implement this policy.

(c) The agency may implement a utilization management program designed to prior authorize home and community-based service plans and includes, but is not limited to, assessing proposed quantity and duration of services and monitoring ongoing service use by participants in the program. The agency is authorized to competitively procure a qualified organization to provide utilization management of home and community-based services. The agency is authorized to seek any federal waivers to implement this initiative.

(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. Payment shall not include bed-hold days except in facilities with occupancy rates of 95 percent or greater. The agency is authorized to seek any federal waiver approvals to implement this policy.

Section 10. Subsection (8) of section 409.9065, Florida Statutes, is renumbered as subsection (9), and a new subsection (8) is added to said section, to read:

409.9065 Pharmaceutical expense assistance.--

(8) PHARMACEUTICAL EXPENSE ASSISTANCE PROGRAM.--In the absence of federal approval for the Lifesaver Rx Program to provide benefits to higher income groups and additional discounts as described in subsections (2) and (3), the Agency for Health Care Administration may, subject to federal approval and continuing state appropriations, operate a pharmaceutical expense assistance program that limits eligibility and benefits to Medicaid beneficiaries who do not normally receive Medicaid benefits, are Florida residents age 65 and older, have an income less than or equal to 120 percent of the federal poverty level, are eligible for Medicare, and request to be enrolled in the program. Benefits under the limited pharmaceutical expense assistance program shall include Medicaid payment for up to $160 per month for prescribed drugs, subject to benefit utilization controls applied to other Medicaid prescribed drug benefits and

the following copayments: $2 per generic product, $5 for a product that is on the Medicaid Preferred Drug List, and $15 for a product that is not on the preferred drug list.

Section 11. Subsection (12) is added to section 409.907, Florida Statutes, to read:

409.907 Medicaid provider agreements.--The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(12) Licensed, certified, or otherwise qualified providers are not entitled to enrollment in a Medicaid provider network.

Section 12. Subsections (4), (14), and (19) of section 409.908, Florida Statutes, are amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or

goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be affected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of

eligibility. The agency shall calculate capitation rates on a regional basis and, beginning September 1, 1995, shall include age-band differentials in such calculations. ~~Effective July 1, 2001, the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals from reimbursement ceilings and the cost of special Medicaid payments shall not be included in premiums paid to health maintenance organizations or prepaid health care plans. Each rate semester, the agency shall calculate and publish a Medicaid hospital rate schedule that does not reflect either special Medicaid payments or the elimination of rate reimbursement ceilings, to be used by hospitals and Medicaid health maintenance organizations, in order to determine the Medicaid rate referred to in ss. 409.912(17), 409.9128(5), and 641.513(6).~~

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The Medicaid maximum allowable fee for ingredient cost will be based on the lower of: average wholesale price (AWP) minus 15.4 percent, wholesaler acquisition cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider. Medicaid providers are required to dispense generic drugs if available at lower cost and the agency has not determined that the branded product is more cost-effective, unless the prescriber has requested and received approval to

require the branded product. The agency is directed to implement a variable dispensing fee for payments for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred-drug-list products. The agency may increase the pharmacy dispensing fee authorized by statute and in the annual General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred-drug list. The agency may establish a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications to stock and crediting the Medicaid program for the ingredient cost of those medications if the ingredient costs to be credited exceed the value of the supplemental dispensing fee. The agency is authorized to limit reimbursement for prescribed medicine in order to comply with any limitations or directions provided for in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

(19) County health department services shall ~~may~~ be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the agency in accordance with federal regulations under the authority of 42 C.F.R. s. 431.615.

Section 13. Section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) Definitions.--As used in this section, s. 409.9112, and the Florida Hospital Uniform Reporting System manual:

(a) "Adjusted patient days" means the sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(b) "Actual audited data" or "actual audited experience" means data reported to the Agency for Health Care Administration which has been audited in accordance with generally accepted auditing standards by the agency or representatives under contract with the agency.

(c) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a

hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.

(d) "Charity care days" means the sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

(e) "Hospital" means a health care institution licensed as a hospital pursuant to chapter 395, but does not include ambulatory surgical centers.

(f) "Medicaid days" means the number of actual days attributable to Medicaid patients as determined by the Agency for Health Care Administration.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

(a) The average of the ~~1997~~, 1998, ~~and~~ 1999<u>, and 2000</u> audited data to determine each hospital's Medicaid days and charity care.

(b) The average of the audited disproportionate share data for the years available if the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share data for a hospital.

(c) In accordance with s. 1923(b) of the Social Security Act, a hospital with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater shall qualify for reimbursement.

(3) Hospitals that qualify for a disproportionate share payment solely under paragraph (2)(c) shall have their payment calculated in accordance with the following formulas:

DSHP = (HMD/TMSD) x $1 million

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSD = total state Medicaid days.

<u>Any funds not allocated to hospitals qualifying under this section shall be redistributed to the non-state government owned or operated hospitals with greater than 3,300 Medicaid days.</u>

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

(a) For state mental health hospitals:

DSHP = (HMD/TMDMH) x TAAMH

shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program.

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TMDHH = total Medicaid days for state mental health hospitals.

TAAMH = total amount available for mental health hospitals.

(b) For non-state government owned or operated hospitals with 3,300 or more Medicaid days:

$$DSHP = [(.82 \times HCCD/TCCD) + (.18 \times HMD/TMD)] \times TAAPH$$

$$TAAPH = TAA - TAAMH$$

Where:

TAA = total available appropriation.

TAAPH = total amount available for public hospitals.

DSHP = disproportionate share hospital payments.

HMD = hospital Medicaid days.

TMD = total state Medicaid days for public hospitals.

HCCD = hospital charity care dollars.

TCCD = total state charity care dollars for public non-state hospitals.

The TAAPH shall be reduced by $6,365,257 before computing the DSHP for each public hospital. The $6,365,257 shall be distributed equally between the public hospitals that are also designated statutory teaching hospitals.

(c) For non-state government owned or operated hospitals with less than 3,300 Medicaid days, a total of $750,000 ~~$400,000~~ shall be distributed equally among these hospitals.

(5) In no case shall total payments to a hospital under this section, with the exception of public non-state facilities or state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the agency according to the most recent calendar year audited data available at the beginning of each state fiscal year.

(6) The agency is authorized to receive funds from local governments and other local political subdivisions for the purpose of making payments, including federal matching funds, through the Medicaid disproportionate share program. Funds received from local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(7) Payments made by the agency to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.

(a) If the Federal Government prohibits, restricts, or changes in any manner the methods by which funds are distributed for this program, the agency shall not distribute any additional funds and shall return all funds to the local government from

which the funds were received, except as provided in paragraph (b).

(b) If the Federal Government imposes a restriction that still permits a partial or different distribution, the agency may continue to disburse funds to hospitals participating in the disproportionate share program in a federally approved manner, provided:

1. Each local government which contributes to the disproportionate share program agrees to the new manner of distribution as shown by a written document signed by the governing authority of each local government; and

2. The Executive Office of the Governor, the Office of Planning and Budgeting, the House of Representatives, and the Senate are provided at least 7 days' prior notice of the proposed change in the distribution, and do not disapprove such change.

(c) No distribution shall be made under the alternative method specified in paragraph (b) unless all parties agree or unless all funds of those parties that disagree which are not yet disbursed have been returned to those parties.

(8) Notwithstanding the provisions of chapter 216, the Executive Office of the Governor is hereby authorized to establish sufficient trust fund authority to implement the disproportionate share program.

(9) The Agency for Health Care Administration shall create a Medicaid Disproportionate Share Council.

(a) The purpose of the council is to study and make recommendations regarding:

1. The formula for the regular disproportionate share program and alternative financing options.

2. Enhanced Medicaid funding through the Special Medicaid Payment program.

3. The federal status of the upper-payment-limit funding option and how this option may be used to promote health care initiatives determined by the council to be state health care priorities.

(b) The council shall include representatives of the Executive Office of the Governor and of the agency; representatives from teaching, public, private nonprofit, private for-profit and family practice teaching hospitals; and representatives from other groups as needed.

(c) The council shall submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

Section 14. Section 409.9112, Florida Statutes, is amended to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of

s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year 2004-2005, the agency shall not distribute moneys under the regional perinatal intensive care centers disproportionate share program, except as noted in subsection (2). In the event the Centers for Medicare and Medicaid Services do not approve Florida’s inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the regional perinatal intensive care centers disproportionate share program.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the regional perinatal intensive care center program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a regional perinatal intensive care center.

HDSP = the prior state fiscal year regional perinatal intensive care center disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total regional perinatal intensive care center disproportionate share payments to all hospitals.

(2) The total additional payment for hospitals that participate in the regional perinatal intensive care center program shall be calculated by the agency as follows:

$$TAP = TAE \times TA$$

Where:

TAP = total additional payment for a regional perinatal intensive care center.

TAE = total amount earned by a regional perinatal intensive care center.

TA = total appropriation for the regional perinatal intensive care center disproportionate share program.

(3) In order to receive payments under this section, a hospital must be participating in the regional perinatal intensive care center program pursuant to chapter 383 and must meet the following additional requirements:

(a) Agree to conform to all departmental and agency requirements to ensure high quality in the provision of services, including criteria adopted by departmental and agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department and agency deem appropriate as specified by rule.

(b) Agree to provide information to the department and agency, in a form and manner to be prescribed by rule of the department and agency, concerning the care provided to all

patients in neonatal intensive care centers and high-risk maternity care.

(c) Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

(d) Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

(e) Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

(f) Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

(g) Agree to provide backup and referral services to the department's county health departments and other low-income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

(h) Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

(4) Hospitals which fail to comply with any of the conditions in subsection (3) or the applicable rules of the department and agency shall not receive any payments under this section until full compliance is achieved. A hospital which is

not in compliance in two or more consecutive quarters shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating regional perinatal intensive care center program hospitals.

Section 15. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year 2004-2005, the agency shall not distribute moneys under the teaching hospital disproportionate share program, except as noted in subsection (2). In the event the Centers for Medicare and Medicaid Services do not approve Florida’s inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the teaching hospital disproportionate share program.

(1) On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals.

(b) The number of full-time equivalent trainees in the hospital, which comprises two components:

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily

assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index that comprises three components:

1. The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as reported on Worksheet A-2 for the last fiscal year reported to the agency

before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Administration Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to the volume of each service, expressed in terms of the standard units of measure reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all state statutory teaching hospitals.

The primary factor for the service index is computed as the sum of these three components, divided by three.

(2) By October 1 of each year, the agency shall use the following formula to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

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

409.9117 Primary care disproportionate share program.-- For the state fiscal year 2004-2005, the agency shall not distribute moneys under the primary care disproportionate share program, except as noted in subsection (2). In the event the Centers for Medicare and Medicaid Services do not approve Florida’s inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the primary care disproportionate share program.

(1) If federal funds are available for disproportionate share programs in addition to those otherwise provided by law, there shall be created a primary care disproportionate share program.

(2) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the primary care disproportionate share program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a hospital participating in the primary care disproportionate share program.

HDSP = the prior state fiscal year primary care disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total primary care disproportionate share payments to all hospitals.

(3) The total additional payment for hospitals that participate in the primary care disproportionate share program shall be calculated by the agency as follows:

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

TA = total appropriation for the primary care disproportionate share program.

(4) In the establishment and funding of this program, the agency shall use the following criteria in addition to those

specified in s. 409.911, payments may not be made to a hospital unless the hospital agrees to:

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

(b) Ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

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

(d) Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible

under this paragraph who do not require emergency room services are referred during normal daylight hours.

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

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

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

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

(i) Work with public health officials and other experts to provide community health education and prevention activities

designed to promote healthy lifestyles and appropriate use of health services.

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

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

Section 17. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may establish prior authorization requirements for certain populations of Medicaid beneficiaries,

certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance record, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency is authorized to seek federal waivers necessary to implement this policy.

(1) The agency shall work with the Department of Children and Family Services to ensure access of children and families in the child protection system to needed and appropriate mental health and substance abuse services.

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

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

(4) The agency may contract with:

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

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed

under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a managed care plan in an AHCA area. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation

paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

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

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and

outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid health maintenance organization ~~plan~~ in AHCA areas where the eligible population exceeds 150,000. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state. ~~The plan shall include provisions which ensure that children and families receiving foster care and other related services are appropriately served and that these services assist the community-based care lead agencies in meeting the goals and outcomes of the child welfare~~

~~system. The plan will be developed with the participation of community-based lead agencies, community alliances, sheriffs, and community providers serving dependent children.~~

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

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

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health

care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

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

8. For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care

and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and The Department of Children and Family Services. The agency is authorized to seek any federal waivers to implement this initiative.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (17) ~~(15)~~ and (18) ~~(16)~~.

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek

federal Medicaid waivers as necessary to implement the provisions of this section.

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

(f) An entity that provides in-home physician services to test the cost-effectiveness of enhanced home-based medical care to Medicaid recipients with degenerative neurological diseases and other diseases or disabling conditions associated with high costs to Medicaid. The program shall be designed to serve very disabled persons and to reduce Medicaid reimbursed costs for inpatient, outpatient, and emergency department services. The agency shall contract with vendors on a risk-sharing basis.

(g) Children's provider networks that provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialty care, and other urgent and emergency care through organized providers designed to service Medicaid eligibles under age 18 and pediatric emergency departments' diversion programs. The

networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's networks rather than hospital emergency departments.

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

(i) A Children's Medical Services network, as defined in s. 391.021.

(5) By October 1, 2003, the agency and the department shall, to the extent feasible, develop a plan for implementing new Medicaid procedure codes for emergency and crisis care, supportive residential services, and other services designed to maximize the use of Medicaid funds for Medicaid-eligible recipients. The agency shall include in the agreement developed pursuant to subsection (4) a provision that ensures that the match requirements for these new procedure codes are met by certifying eligible general revenue or local funds that are currently expended on these services by the department with contracted alcohol, drug abuse, and mental health providers. The plan must describe specific procedure codes to be implemented, a projection of the number of procedures to be delivered during

fiscal year 2003-2004, and a financial analysis that describes the certified match procedures, and accountability mechanisms, projects the earnings associated with these procedures, and describes the sources of state match. This plan may not be implemented in any part until approved by the Legislative Budget Commission. If such approval has not occurred by December 31, 2003, the plan shall be submitted for consideration by the 2004 Legislature.

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

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

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

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

(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid

premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

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

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

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

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

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

(b) Assumes the underwriting risk; and

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

(8) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law.

(9) The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-

service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization.

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

(a) Fraud;

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

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

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

(11) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as

necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

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

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

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

(13) The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such

systems of care among public and private health care providers in a given geographic area.

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

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

(b) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs.

(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the individual requires nursing facility care and that the individual cannot be safely served in community-based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program.

(d) By January 1 of each year, the agency shall submit a report to the Legislature and the Office of Long-Term-Care

Policy describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

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

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

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

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

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

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

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

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

4. By September 30, 2002, the agency shall contract with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for practitioners. The initiative shall be designed to enhance the agency's efforts to reduce fraud, abuse, and errors in the prescription drug benefit program and to otherwise further the intent of this paragraph.

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

(17) An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Office of Insurance Regulation, and restricted funds or deposits controlled by the agency or the Office of Insurance Regulation, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid

revenues. As used in this subsection, the term "surplus" means the entity's total assets minus total liabilities. If an entity's surplus falls below an amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

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

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

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

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

(18)(a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in this state. The entity shall deposit into that account 5 percent of the capitation payments made by the agency each month until a maximum total of 2 percent of the total current contract amount is reached. The restricted insolvency protection account may be drawn upon with

the authorized signatures of two persons designated by the entity and two representatives of the agency. If the agency finds that the entity is insolvent, the agency may draw upon the account solely with the two authorized signatures of representatives of the agency, and the funds may be disbursed to meet financial obligations incurred by the entity under the prepaid contract. If the contract is terminated, expired, or not continued, the account balance must be released by the agency to the entity upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (24) ~~(22)~~.

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

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

(f) Enrollment of Medicaid recipients.

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

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

(24) Upon approval by the agency, health maintenance organizations and persons or entities exempt from chapter 641 that are under contract with the agency for the provision of health care services to Medicaid recipients may be permitted within the capitation rate to provide additional health benefits that the agency has found are of high quality, are practicably

available, provide reasonable value to the recipient, and are provided at no additional cost to the state.

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

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

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

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

1. Written quality assurance program descriptions.

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

3. An active quality assurance committee.

4. Quality assurance program supervision.

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

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

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

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

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

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

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

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

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

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

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

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

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

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

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

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

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

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

(29) The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (21)~~(19)~~(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its

agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract.

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

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

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

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

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

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

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

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

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

(33) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such

request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs.

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

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

(a) Healthy Start prenatal or infant screening.

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

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

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

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

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

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

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

(37) The agency may seek and implement federal waivers necessary to provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, and durable medical equipment and supplies through competitive bidding pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid such services. The agency may exclude providers not selected through the bidding process from the Medicaid provider network.

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

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

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

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

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

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

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

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

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

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

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

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

1. Medicaid prescribed-drug coverage for brand-name drugs for adult Medicaid recipients is limited to the dispensing of four brand-name drugs per month per recipient. Children are exempt from this restriction. Antiretroviral agents are excluded from this limitation. No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available without restriction for persons with mental illnesses include atypical antipsychotic medications, conventional antipsychotic medications, selective serotonin reuptake inhibitors, and other medications used for the treatment of serious mental illnesses. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply. The agency shall continue to provide unlimited generic drugs, contraceptive drugs and items, and diabetic supplies. Although a drug may be included on the preferred drug formulary, it would not be exempt from the four-brand limit. The agency may authorize exceptions to the brand-name-drug restriction based

upon the treatment needs of the patients, only when such exceptions are based on prior consultation provided by the agency or an agency contractor, but the agency must establish procedures to ensure that:

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

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

c. Except for the exception for nursing home residents and other institutionalized adults and except for drugs on the restricted formulary for which prior authorization may be sought by an institutional or community pharmacy, prior authorization for an exception to the brand-name-drug restriction is sought by the prescriber and not by the pharmacy. When prior authorization is granted for a patient in an institutional setting beyond the brand-name-drug restriction, such approval is authorized for 12 months and monthly prior authorization is not required for that patient.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: the average wholesale price (AWP) minus 15.4 percent, the wholesaler acquisition cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider ~~the average wholesale price less 13.25 percent~~.

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

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

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

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

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

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 ~~10~~ percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 ~~25~~ percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will

consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means ~~may include, at the agency's discretion,~~ cash rebates ~~and other program benefits that offset a Medicaid expenditure~~. Effective July 1, 2004, value-added programs as a substitution for supplemental rebates are prohibited. ~~Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act.~~ The agency is authorized to seek any federal waivers to implement this initiative.

8. The agency shall establish an advisory committee for the purposes of studying the feasibility of using a restricted drug formulary for nursing home residents and other institutionalized adults. The committee shall be comprised of seven members appointed by the Secretary of Health Care

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

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

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

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

b. The agency, in conjunction with the Department of Children and Family Services, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to

medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program shall include the following elements:

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

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

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

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

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

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

c. If the agency is unable to negotiate a contract with one or more manufacturers to finance and guarantee savings associated with a behavioral drug management program by September 1, 2004, the four-brand drug limit and preferred drug list prior-authorization requirements shall apply to mental-health-related drugs, notwithstanding any provision in subparagraph 1. The agency is authorized to seek federal waivers to implement this policy.

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

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

14. The agency may require prior authorization for the off-label use of Medicaid-covered prescribed drugs as specified in the General Appropriations Act. The agency may, but is not required to, preauthorize the use of a product for an indication not in the approved labeling. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the off-label use of a drug.

15. The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner.

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

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

(41) 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.

(42) 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.

(43) The agency shall develop and implement a utilization management program for Medicaid-eligible recipients for the management of occupational, physical, respiratory, and speech therapies. The agency shall establish a utilization program that may require prior authorization in order to ensure medically necessary and cost-effective treatments. The program shall be operated in accordance with a federally approved waiver program or state plan amendment. The agency may seek a federal waiver or state plan amendment to implement this program. The agency may

also competitively procure these services from an outside vendor on a regional or statewide basis.

(44) The agency may contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services.

(45) The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(h), whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31 of each year. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

Section 18. Paragraphs (a) and (e) of subsection (2) of section 409.9122, Florida Statutes, are amended, and subsection (14) is added to said section, to read:

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

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

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

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

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

The agency shall develop rules to establish policies by which exceptions to the mandatory managed care enrollment requirement may be made on a case-by-case basis. The rules shall include the specific criteria to be applied when making a determination as to whether to exempt a recipient from mandatory enrollment in a managed care plan or MediPass. School districts participating in the certified school match program pursuant to ss. 409.908(21)

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

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 ~~90~~ days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice shall be assigned to a

managed care plan or MediPass in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

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

Section 19. Section 409.9124, Florida Statutes, is amended to read:

409.9124 Managed care reimbursement.--

(1) The agency shall develop and adopt by rule a methodology for reimbursing managed care plans.

(2) Final rates shall be published annually prior to September 1 of each year, based on methodology that:

(a) Uses Medicaid’s fee-for-service expenditures.

(b) Is certified as an actuarially sound computation of Medicaid fee-for-service expenditures for comparable groups of Medicaid recipients and includes all fee-for-service expenditures, including those fee-for-service expenditures attributable to recipients who are enrolled for a portion of a year in a managed care plan or waiver program.

(c) Is compliant with applicable federal laws and regulations, including, but not limited to, the requirements to include an allowance for administrative expenses and to account for all fee-for service expenditures, including fee-for-service expenditures for those groups enrolled for part of a year.

(3) Each year prior to establishing new managed care rates, the agency shall review all prior year adjustments for changes in trend, and shall reduce or eliminate those adjustments which are not reasonable and which reflect policies or programs which are not in effect.

(4)~~(2)~~ The agency shall by rule prescribe those items of financial information which each managed care plan shall report to the agency, in the time periods prescribed by rule. In prescribing items for reporting and definitions of terms, the agency shall consult with the Office of Insurance Regulation of the Financial Services Commission wherever possible.

(5)~~(3)~~ The agency shall quarterly examine the financial condition of each managed care plan, and its performance in serving Medicaid patients, and shall utilize examinations performed by the Office of Insurance Regulation wherever possible.

Section 20. Paragraph (b) of subsection (5) of section 624.91, Florida Statutes, as amended by chapter 2004-1, Laws of Florida, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

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

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

2. Arrange for the collection of any voluntary contributions to provide for payment of premiums for children who are not eligible for medical assistance under Title XXI of the Social Security Act. Each fiscal year, the corporation shall establish a local match policy for the enrollment of non-Title-XXI-eligible children in the Healthy Kids program. By May 1 of each year, the corporation shall provide written notification of the amount to be remitted to the corporation for the following fiscal year under that policy. Local match sources may include, but are not limited to, funds provided by municipalities, counties, school boards, hospitals, health care providers, charitable organizations, special taxing districts, and private organizations. The minimum local match cash contributions required each fiscal year and local match credits shall be determined by the General Appropriations Act. The corporation shall calculate a county's local match rate based upon that county's percentage of the state's total non-Title-XXI

expenditures as reported in the corporation's most recently audited financial statement. In awarding the local match credits, the corporation may consider factors including, but not limited to, population density, per capita income, and existing child-health-related expenditures and services.

3. Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional coverage in contributing counties under Title XXI.

4. Establish the administrative and accounting procedures for the operation of the corporation.

5. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

6. Determine eligibility for children seeking to participate in the Title XXI-funded components of the Florida KidCare program consistent with the requirements specified in s. 409.814, as well as the non-Title-XXI-eligible children as provided in subsection (3).

7. Establish procedures under which providers of local match to, applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.

8. Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

9. Establish enrollment criteria which shall include penalties or waiting periods of not fewer than 60 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums.

10. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail. The health plan selection criteria and scoring system,

and the scoring results, shall be available upon request for inspection after the bids have been awarded.

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

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

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

14. Provide a report annually to the Governor, Chief Financial Officer, Commissioner of Education, Senate President, Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives.

15. Establish benefit packages which conform to the provisions of the Florida KidCare program, as created in ss. 409.810-409.820.

Section 21. Notwithstanding s. 430.707, Florida Statutes, no later than September 1, 2005, subject to federal approval of the application to be a Program of All-inclusive Care for the Elderly site, the agency shall contract with one private, not-for-profit hospice organization located in Lee County and one such organization in Martin County, such an entity shall be exempt from the requirements of chapter 641 Florida Statutes, each of which provides comprehensive services, including hospice

care for frail and elderly persons. The agency shall approve 100 initial enrollees in the Program of All-inclusive Care for the Elderly in Lee and Martin counties. There shall be 50 initial enrollees in each county.

Section 22. In order to improve affordability and provide coverage for more facilities for residents of the state, the agency shall renegotiate the terms, conditions, and duration of its loan to the Long Term Care Risk Retention Group to provide that participating skilled nursing facilities be required to pay no more than $65 per bed for capitalization costs and participating adult living facilities will be required to pay no more than $33 per bed for capitalization costs.

Section 23. The Office of Program Policy Analysis and Government Accountability shall perform a review of optional Medicaid coverage for pregnant women, adult dentures, and the medically needy. The review shall determine the cost benefit to the state of providing these optional Medicaid items to Medicaid recipients. A report on the findings of the review shall be provided to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 2005.

Section 24. The Agency for Health Care Administration may contract on a capitated, prepaid, or fixed-sum basis with a laboratory service provider to provide statewide laboratory services for Medicaid recipients. The contract is not subject to any requirement of the Florida Insurance Code. Whether or not the agency procures statewide laboratory services, the agency shall ensure that it secures laboratory values from Medicaid-

enrolled laboratories for all tests provided to Medicaid recipients. Such data shall be included in the Medicaid real-time web-based reporting system that interfaces with a real-time web-based prescription ordering and tracking system as required by the 2003-2004 General Appropriations Act.

Section 25. Except as otherwise provided herein, this act shall take effect July 1, 2004.

================ T I T L E A M E N D M E N T ================

Remove the entire title and insert:

A bill to be entitled

An act relating to health care; amending s. 400.23, F.S.; delaying a nursing home staffing increase; providing for retroactive application; amending s. 408.909, F.S.; providing additional eligibility; amending s. 409.8134, F.S.; revising a date for eligibility to be exempt from reapplying; amending s. 409.814, F.S.; providing additional eligibility for KidCare; requiring proof of family income with supporting documents; amending s. 409.903, F.S.; eliminating services for certain persons; providing income deductions; amending s. 409.905, F.S., relating to mandatory Medicaid services; requiring utilization management of private duty nursing services; establishing a hospitalist program; limiting payment for bed hold days for nursing facilities; amending s. 409.906, F.S., relating to optional Medicaid services; providing for adult denture and adult hearing and visual services; eliminating vacancy interim rates for intermediate care

facility for the developmentally disabled services; requiring utilization management for home and community-based services; consolidating home and community-based services; amending s. 409.9065, F.S.; authorizing the agency to operate a pharmaceutical expense assistance program under certain circumstances; amending s. 409.907, F.S.; revising Medicaid provider agreement requirements; amending s. 409.908, F.S.; revising guidelines relating to reimbursement of Medicaid providers; mandating the payment method of county health departments; amending s. 409.911, F.S.; requiring the convening of the Medicaid Disproportionate Share Council and providing duties thereof; amending ss. 409.9112, 409.9113, and 409.9117, F.S.; restricting the agency from distributing certain funds; amending s. 409.912, F.S.; granting Medicaid provider network management; providing limits on certain drugs; providing for management of mental health drugs; reducing payment for pharmaceutical ingredient prices; expanding the existing pharmaceutical supplemental rebate threshold; correcting cross references; amending s. 409.9124, F.S.; requiring the agency to publish managed care rates annually; amending s. 624.91, F.S.; revising Healthy Kids contract requirements; requiring certain programs be provided in certain counties; requiring the agency to negotiate to reduce costs; requiring a review by the Office of Program Policy Analysis and Government Accountability; requiring a report; authorizing the Agency for Health Care Administration to contract on a capitated,

prepaid, or fixed-sum basis with a laboratory service provider to provide statewide laboratory services for Medicaid recipients; requiring the agency to ensure that it secures laboratory values from Medicaid-enrolled laboratories for all tests provided to Medicaid recipients and to include such data in the Medicaid real-time web-based reporting system that interfaces with a real time web-based prescription ordering and tracking system; providing effective dates.