Bill No. HB 1843, 1st Eng.

Amendment No. ___ Barcode 741832

CHAMBER ACTION

Senate		House
1/AD/3R 04/08/2004 02:05 PM	.	

Senator Peaden moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Section 216.341, Florida Statutes, is amended to read:

216.341 Disbursement of Department of Health ~~county health department~~ trust funds; appropriation of authorized positions.--

(1) County health department trust funds may be expended by the Department of Health for the respective county health departments in accordance with budgets and plans agreed upon by the county authorities of each county and the Department of Health.

(2) The requirement ~~limitations on appropriations~~ provided in s. 216.262(1) shall not apply to Department of Health positions funded by:

(a) County health department trust funds; or~~.~~

(b) The United States Trust Fund.

Section 2. Effective 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 standards ~~requirements~~ for nursing homes. These standards ~~requirements~~ shall require ~~include~~, in ~~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, and 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 May 1, 2004~~. Beginning January 1, 2002, no facility shall staff below one certified nursing assistant per 20 residents, and a minimum licensed nursing staffing of 1.0 hour of direct resident care per resident per day but never below one licensed nurse per 40 residents. Nursing assistants employed 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

1 certified nursing assistant. Unless otherwise approved by the
2 agency, licensed nurses counted towards the minimum staffing
3 requirements for certified nursing assistants must exclusively
4 perform the duties of a certified nursing assistant for the
5 entire shift and shall not also be counted towards the minimum
6 staffing requirements for licensed nurses. If the agency
7 approved a facility's request to use a licensed nurse to
8 perform both licensed nursing and certified nursing assistant
9 duties, the facility must allocate the amount of staff time
10 specifically spent on each set of ~~certified nursing assistant~~
11 duties for the purpose of documenting compliance with minimum
12 staffing requirements for certified and licensed nursing
13 staff. In no event may the hours of a licensed nurse with dual
14 job responsibilities be counted twice.
15 Section 3. Section 409.814, Florida Statutes, as
16 amended by CS for SB 2000, 1st engrossed, is amended to read:
17 409.814 Eligibility.--A child who has not reached 19
18 years of age whose family income is equal to or below 200
19 percent of the federal poverty level is eligible for the
20 Florida KidCare program as provided in this section. A child
21 who is otherwise eligible for KidCare and who has a
22 preexisting condition that prevents coverage under another
23 insurance plan as described in subsection (4) which would have
24 disqualified the child for KidCare if the child were able to
25 enroll in the plan shall be eligible for KidCare coverage when
26 enrollment is possible. For enrollment in the Children's
27 Medical Services network, a complete application includes the
28 medical or behavioral health screening. If, subsequently, an
29 individual is determined to be ineligible for coverage, he or
30 she must immediately be disenrolled from the respective
31 Florida KidCare program component.

1 (1) A child who is eligible for Medicaid coverage
2 under s. 409.903 or s. 409.904 must be enrolled in Medicaid
3 and is not eligible to receive health benefits under any other
4 health benefits coverage authorized under the Florida KidCare
5 program.
6 (2) A child who is not eligible for Medicaid, but who
7 is eligible for the Florida KidCare program, may obtain health
8 benefits coverage under any of the other components listed in
9 s. 409.813 if such coverage is approved and available in the
10 county in which the child resides. However, a child who is
11 eligible for Medikids may participate in the Florida Healthy
12 Kids program only if the child has a sibling participating in
13 the Florida Healthy Kids program and the child's county of
14 residence permits such enrollment.
15 (3) A child who is eligible for the Florida KidCare
16 program who is a child with special health care needs, as
17 determined through a medical or behavioral screening
18 instrument, is eligible for health benefits coverage from and
19 shall be referred to the Children's Medical Services network.
20 (4) The following children are not eligible to receive
21 premium assistance for health benefits coverage under the
22 Florida KidCare program, except under Medicaid if the child
23 would have been eligible for Medicaid under s. 409.903 or s.
24 409.904 as of June 1, 1997:
25 (a) A child who is eligible for coverage under a state
26 health benefit plan on the basis of a family member's
27 employment with a public agency in the state.
28 (b) A child who is currently eligible for or covered
29 under a family member's group health benefit plan or under
30 other employer health insurance coverage, excluding coverage
31 provided under the Florida Healthy Kids Corporation as

1 established under s. 624.91, provided that the cost of the
2 child's participation is not greater than 5 percent of the
3 family's income. This provision shall be applied during
4 redetermination for children who were enrolled prior to July
5 1, 2004. These enrollees shall have 6 months of eligibility
6 following redetermination to allow for a transition to the
7 other health benefit plan.
8 (c) A child who is seeking premium assistance for the
9 Florida KidCare program through employer-sponsored group
10 coverage, if the child has been covered by the same employer's
11 group coverage during the 6 months prior to the family's
12 submitting an application for determination of eligibility
13 under the program.
14 (d) A child who is an alien, but who does not meet the
15 definition of qualified alien, in the United States.
16 (e) A child who is an inmate of a public institution
17 or a patient in an institution for mental diseases.
18 (f) A child who has had his or her coverage in an
19 employer-sponsored health benefit plan voluntarily canceled in
20 the last 6 months, except those children who were on the
21 waiting list prior to January 31, 2004.
22 (5) A child ~~whose family income is above 200 percent~~
23 ~~of the federal poverty level or a child~~ who is excluded under
24 the provisions of subsection (4) may participate in the
25 Florida KidCare program, excluding the Medicaid program, but
26 is subject to the following provisions:
27 (a) The family is not eligible for premium assistance
28 payments and must pay the full cost of the premium, including
29 any administrative costs.
30 (b) The agency is authorized to place limits on
31 enrollment in Medikids by these children in order to avoid

1 adverse selection. The number of children participating in
2 Medikids whose family income exceeds 200 percent of the
3 federal poverty level must not exceed 10 percent of total
4 enrollees in the Medikids program.
5 (c) The board of directors of the Florida Healthy Kids
6 Corporation is authorized to place limits on enrollment of
7 these children in order to avoid adverse selection. In
8 addition, the board is authorized to offer a reduced benefit
9 package to these children in order to limit program costs for
10 such families. The number of children participating in the
11 Florida Healthy Kids program whose family income exceeds 200
12 percent of the federal poverty level must not exceed 10
13 percent of total enrollees in the Florida Healthy Kids
14 program.
15 (d) Children described in this subsection are not
16 counted in the annual enrollment ceiling for the Florida
17 KidCare program.
18 (6) Once a child is enrolled in the Florida KidCare
19 program, the child is eligible for coverage under the program
20 for 6 months without a redetermination or reverification of
21 eligibility, if the family continues to pay the applicable
22 premium. Eligibility for program components funded through
23 Title XXI of the Social Security Act shall terminate when a
24 child attains the age of 19. Effective January 1, 1999, a
25 child who has not attained the age of 5 and who has been
26 determined eligible for the Medicaid program is eligible for
27 coverage for 12 months without a redetermination or
28 reverification of eligibility.
29 (7) When determining or reviewing a child's
30 eligibility under the Florida KidCare program, the applicant
31 shall be provided with reasonable notice of changes in

1 eligibility which may affect enrollment in one or more of the
2 program components. When a transition from one program
3 component to another is authorized, there shall be cooperation
4 between the program components and the affected family which
5 promotes continuity of health care coverage. Any authorized
6 transfers must be managed within the program's overall
7 appropriated or authorized levels of funding. Each component
8 of the program shall establish a reserve to ensure that
9 transfers between components will be accomplished within
10 current year appropriations. These reserves shall be reviewed
11 by each convening of the Social Services Estimating Conference
12 to determine the adequacy of such reserves to meet actual
13 experience.
14 (8) In determining the eligibility of a child, an
15 assets test is not required. Each applicant shall provide
16 written documentation during the application process and the
17 redetermination process, including, but not limited to, the
18 following:
19 (a) Proof of family income supported by copies of any
20 federal income tax return for the prior year, any wages and
21 earning statements, (W-2 forms), and any other document the
22 agency finds necessary.
23 (b) A statement from all family members that:
24 1. Their employer does not sponsor a health benefit
25 plan for employees; or
26 2. The potential enrollee is not covered by the
27 employer-sponsored health benefit plan because the potential
28 enrollee is not eligible for coverage, or, if the potential
29 enrollee is eligible but not covered, a statement of the cost
30 to enroll the potential enrollee in the employer-sponsored
31 health benefit plan.

1 (9) Subject to paragraph (4)(b) and s. 624.91(3), the
2 Florida KidCare program shall withhold benefits from an
3 enrollee if the program obtains evidence that the enrollee is
4 no longer eligible, submitted incorrect or fraudulent
5 information in order to establish eligibility, or failed to
6 provide verification of eligibility. The applicant or enrollee
7 shall be notified that because of such evidence program
8 benefits will be withheld unless the applicant or enrollee
9 contacts a designated representative of the program by a
10 specified date, which must be within 10 days after the date of
11 notice, to discuss and resolve the matter. The program shall
12 make every effort to resolve the matter within a timeframe
13 that will not cause benefits to be withheld from an eligible
14 enrollee.
15 (10) The following individuals may be subject to
16 prosecution in accordance with s. 414.39:
17 (a) An applicant obtaining or attempting to obtain
18 benefits for a potential enrollee under the Florida KidCare
19 program when the applicant knows or should have known the
20 potential enrollee does not qualify for the Florida KidCare
21 program.
22 (b) An individual who assists an applicant in
23 obtaining or attempting to obtain benefits for a potential
24 enrollee under the Florida KidCare program when the individual
25 knows or should have known the potential enrollee does not
26 qualify for the Florida KidCare program.
27 Section 4. Subsection (5) of section 409.903, Florida
28 Statutes, is amended to read:
29 409.903 Mandatory payments for eligible persons.--The
30 agency shall make payments for medical assistance and related
31 services on behalf of the following persons who the

1 department, or the Social Security Administration by contract
2 with the Department of Children and Family Services,
3 determines to be eligible, subject to the income, assets, and
4 categorical eligibility tests set forth in federal and state
5 law. Payment on behalf of these Medicaid eligible persons is
6 subject to the availability of moneys and any limitations
7 established by the General Appropriations Act or chapter 216.
8 (5) Effective October 1, 2004, a pregnant woman for
9 the duration of her pregnancy and for the postpartum period as
10 defined in federal law and rule, or a child under age 1, if
11 either is living in a family that has an income which is at or
12 below 150 percent of the most current federal poverty level~~,~~
13 ~~or, effective January 1, 1992, that has an income which is at~~
14 ~~or below 185 percent of the most current federal poverty~~
15 ~~level~~. Such a person is not subject to an assets test.
16 Further, a pregnant woman who applies for eligibility for the
17 Medicaid program through a qualified Medicaid provider must be
18 offered the opportunity, subject to federal rules, to be made
19 presumptively eligible for the Medicaid program.
20 Section 5. Subsections (2), (3), and (8) of section
21 409.904, Florida Statutes, are amended to read:
22 409.904 Optional payments for eligible persons.--The
23 agency may make payments for medical assistance and related
24 services on behalf of the following persons who are determined
25 to be eligible subject to the income, assets, and categorical
26 eligibility tests set forth in federal and state law. Payment
27 on behalf of these Medicaid eligible persons is subject to the
28 availability of moneys and any limitations established by the
29 General Appropriations Act or chapter 216.
30 (2) A family, a pregnant woman, a child under age 21,
31 a person age 65 or over, or a blind or disabled person, who

1 would be eligible under any group listed in s. 409.903(1),
2 (2), or (3), except that the income or assets of such family
3 or person exceed established limitations. For a family or
4 person in one of these coverage groups, medical expenses are
5 deductible from income in accordance with federal requirements
6 in order to make a determination of eligibility. Children and
7 pregnant women ~~A family or person~~ eligible under the coverage
8 known as the "medically needy~~,~~" are ~~is~~ eligible to receive the
9 same services as other Medicaid recipients, with the exception
10 of services in skilled nursing facilities and intermediate
11 care facilities for the developmentally disabled. Effective
12 January 1, 2005, parents or caretaker relatives of children
13 eligible under the coverage known as "medically needy" and
14 aged, blind, or disabled persons eligible under such coverage
15 are limited to pharmacy services only.

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

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

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

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

31 (8) Effective October 1, 2004, a child under 1 year of

age who lives in a family that has an income above 150 ~~185~~ percent of the most recently published federal poverty level, but which is at or below 200 percent of such poverty level. In determining the eligibility of such child, an assets test is not required. A child who is eligible for Medicaid under this subsection must be offered the opportunity, subject to federal rules, to be made presumptively eligible.

Section 6. Section 409.905, Florida Statutes, is 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.

(1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.--The agency shall pay for services provided to a recipient by a licensed advanced registered nurse practitioner who has a valid collaboration agreement with a licensed physician on file with the Department of Health or who provides anesthesia services in accordance with established protocol required by state law and approved by the medical

1 staff of the facility in which the anesthetic service is
2 performed. Reimbursement for such services must be provided in
3 an amount that equals not less than 80 percent of the
4 reimbursement to a physician who provides the same services,
5 unless otherwise provided for in the General Appropriations
6 Act.
7 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND
8 TREATMENT SERVICES.--The agency shall pay for early and
9 periodic screening and diagnosis of a recipient under age 21
10 to ascertain physical and mental problems and conditions and
11 provide treatment to correct or ameliorate these problems and
12 conditions. These services include all services determined by
13 the agency to be medically necessary for the treatment,
14 correction, or amelioration of these problems, including
15 personal care, private duty nursing, durable medical
16 equipment, physical therapy, occupational therapy, speech
17 therapy, respiratory therapy, and immunizations.
18 (3) FAMILY PLANNING SERVICES.--The agency shall pay
19 for services necessary to enable a recipient voluntarily to
20 plan family size or to space children. These services include
21 information; education; counseling regarding the availability,
22 benefits, and risks of each method of pregnancy prevention;
23 drugs and supplies; and necessary medical care and followup.
24 Each recipient participating in the family planning portion of
25 the Medicaid program must be provided freedom to choose any
26 alternative method of family planning, as required by federal
27 law.
28 (4) HOME HEALTH CARE SERVICES.--The agency shall pay
29 for nursing and home health aide services, supplies,
30 appliances, and durable medical equipment, necessary to assist
31 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) Effective November 1, 2004, the agency shall implement a comprehensive utilization program that requires prior authorization of all private duty nursing services for children, including children served by the Department of Health's Children's Medical Services program. The agency may competitively bid a contract to select a qualified organization to provide such services. The agency may seek federal waiver approval as necessary to implement this policy.

(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 specified in the annual ~~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

1 for individuals 21 years of age and older; authorization of
2 emergency and urgent-care admissions within 24 hours after
3 admission; enhanced utilization and concurrent review programs
4 for highly utilized services; reduction or elimination of
5 covered days of service; adjusting reimbursement ceilings for
6 variable costs; adjusting reimbursement ceilings for fixed and
7 property costs; and implementing target rates of increase. The
8 agency may limit prior authorization for hospital inpatient
9 services to selected diagnosis-related groups, based on an
10 analysis of the cost and potential for unnecessary
11 hospitalizations represented by certain diagnoses. Admissions
12 for normal delivery and newborns are exempt from requirements
13 for prior authorization. In implementing the provisions of
14 this section related to prior authorization, the agency shall
15 ensure that the process for authorization is accessible 24
16 hours per day, 7 days per week and authorization is
17 automatically granted when not denied within 4 hours after the
18 request. Authorization procedures must include steps for
19 review of denials. Upon implementing the prior authorization
20 program for hospital inpatient services, the agency shall
21 discontinue its hospital retrospective review program.
22 (b) A licensed hospital maintained primarily for the
23 care and treatment of patients having mental disorders or
24 mental diseases is not eligible to participate in the hospital
25 inpatient portion of the Medicaid program except as provided
26 in federal law. However, subject to federal Medicaid waiver
27 approval, the agency may pay for ~~the department shall apply~~
28 ~~for a waiver, within 9 months after June 5, 1991, designed to~~
29 ~~provide~~ hospitalization services for mental health reasons to
30 children and adults ~~in the most cost-effective and lowest cost~~
31 ~~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 agency ~~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

1 to the agency for a rate adjustment after July 1, 2000, but
2 before September 30, 2000, in which case such hospital's
3 Medicaid inpatient per diem rate shall be adjusted to cost,
4 effective July 1, 2002.
5
6 No later than October 1 of each year, the agency must provide
7 estimated costs for any adjustment in a hospital inpatient per
8 diem pursuant to this paragraph to the Executive Office of the
9 Governor, the House of Representatives General Appropriations
10 Committee, and the Senate Appropriations Committee. Before the
11 agency implements a change in a hospital's inpatient per diem
12 rate pursuant to this paragraph, the Legislature must have
13 specifically appropriated sufficient funds in the General
14 Appropriations Act to support the increase in cost as
15 estimated by the agency.
16 (d) Effective September 1, 2004, the agency shall
17 implement a hospitalist program in certain high-volume
18 participating hospitals, in select counties or statewide. The
19 program shall require hospitalists to authorize and manage
20 Medicaid recipients' hospital admissions and lengths of stay.
21 Individuals who are dually eligible for Medicare and Medicaid
22 are exempted from this requirement. Medicaid participating
23 physicians and other practitioners with hospital admitting
24 privileges shall coordinate and review admissions of Medicaid
25 beneficiaries with the hospitalist. The agency may
26 competitively bid a contract for selection of a qualified
27 organization to provide hospitalist services. The agency may
28 seek federal waiver approval as necessary to implement this
29 policy.
30 (e) Effective November 1, 2004, the agency shall
31 implement a comprehensive utilization management program for

1 hospital neonatal intensive care stays in certain high-volume
2 Medicaid participating hospitals, in select counties or
3 statewide, and shall replace existing hospital inpatient
4 utilization management programs. The program shall be
5 designed to manage the lengths of stay for children being
6 treated in neonatal intensive care units and must seek the
7 earliest medically appropriate discharge to the child's home
8 or other less costly treatment setting. The agency may
9 competitively bid a contract for selection of a qualified
10 organization to provide neonatal intensive care utilization
11 management services. The agency may seek federal waiver
12 approval as necessary to implement this policy.
13 (6) HOSPITAL OUTPATIENT SERVICES.--The agency shall
14 pay for preventive, diagnostic, therapeutic, or palliative
15 care and other services provided to a recipient in the
16 outpatient portion of a hospital licensed under part I of
17 chapter 395, and provided under the direction of a licensed
18 physician or licensed dentist, except that payment for such
19 care and services is limited to $1,500 per state fiscal year
20 per recipient, unless an exception has been made by the
21 agency, and with the exception of a Medicaid recipient under
22 age 21, in which case the only limitation is medical
23 necessity.
24 (7) INDEPENDENT LABORATORY SERVICES.--The agency shall
25 pay for medically necessary diagnostic laboratory procedures
26 ordered by a licensed physician or other licensed practitioner
27 of the healing arts which are provided for a recipient in a
28 laboratory that meets the requirements for Medicare
29 participation and is licensed under chapter 483, if required.
30 (8) NURSING FACILITY SERVICES.--The agency shall pay
31 for 24-hour-a-day nursing and rehabilitative services for a

1 recipient in a nursing facility licensed under part II of
2 chapter 400 or in a rural hospital, as defined in s. 395.602,
3 or in a Medicare certified skilled nursing facility operated
4 by a hospital, as defined by s. 395.002(11), that is licensed
5 under part I of chapter 395, and in accordance with provisions
6 set forth in s. 409.908(2)(a), which services are ordered by
7 and provided under the direction of a licensed physician.
8 However, if a nursing facility has been destroyed or otherwise
9 made uninhabitable by natural disaster or other emergency and
10 another nursing facility is not available, the agency must pay
11 for similar services temporarily in a hospital licensed under
12 part I of chapter 395 provided federal funding is approved and
13 available.
14 (9) PHYSICIAN SERVICES.--The agency shall pay for
15 covered services and procedures rendered to a recipient by, or
16 under the personal supervision of, a person licensed under
17 state law to practice medicine or osteopathic medicine. These
18 services may be furnished in the physician's office, the
19 Medicaid recipient's home, a hospital, a nursing facility, or
20 elsewhere, but shall be medically necessary for the treatment
21 of an injury, illness, or disease within the scope of the
22 practice of medicine or osteopathic medicine as defined by
23 state law. The agency shall not pay for services that are
24 clinically unproven, experimental, or for purely cosmetic
25 purposes.
26 (10) PORTABLE X-RAY SERVICES.--The agency shall pay
27 for professional and technical portable radiological services
28 ordered by a licensed physician or other licensed practitioner
29 of the healing arts which are provided by a licensed
30 professional in a setting other than a hospital, clinic, or
31 office of a physician or practitioner of the healing arts, on

1 behalf of a recipient.
2 (11) RURAL HEALTH CLINIC SERVICES.--The agency shall
3 pay for outpatient primary health care services for a
4 recipient provided by a clinic certified by and participating
5 in the Medicare program which is located in a federally
6 designated, rural, medically underserved area and has on its
7 staff one or more licensed primary care nurse practitioners or
8 physician assistants, and a licensed staff supervising
9 physician or a consulting supervising physician.
10 (12) TRANSPORTATION SERVICES.--The agency shall ensure
11 that appropriate transportation services are available for a
12 Medicaid recipient in need of transport to a qualified
13 Medicaid provider for medically necessary and
14 Medicaid-compensable services, provided a recipient's ~~client's~~
15 ability to choose a specific transportation provider is ~~shall~~
16 ~~be~~ limited to those options resulting from policies
17 established by the agency to meet the fiscal limitations of
18 the General Appropriations Act. Effective January 1, 2005,
19 except for persons who meet Medicaid disability standards
20 adopted by rule, nonemergency transportation services may not
21 be offered to nondisabled recipients if public transportation
22 is generally available in the beneficiary's community. The
23 agency may pay for transportation and other related travel
24 expenses as necessary only if these services are not otherwise
25 available. The agency may competitively bid and contract with
26 a statewide vendor on a capitated basis for the provision of
27 nonemergency transportation services. The agency may seek
28 federal waiver approval as necessary to implement this
29 subsection.
30 Section 7. Subsections (13), (14), and (15) of section
31 409.906, Florida Statutes, are amended to read:

1 409.906 Optional Medicaid services.--Subject to
2 specific appropriations, the agency may make payments for
3 services which are optional to the state under Title XIX of
4 the Social Security Act and are furnished by Medicaid
5 providers to recipients who are determined to be eligible on
6 the dates on which the services were provided. Any optional
7 service that is provided shall be provided only when medically
8 necessary and in accordance with state and federal law.
9 Optional services rendered by providers in mobile units to
10 Medicaid recipients may be restricted or prohibited by the
11 agency. Nothing in this section shall be construed to prevent
12 or limit the agency from adjusting fees, reimbursement rates,
13 lengths of stay, number of visits, or number of services, or
14 making any other adjustments necessary to comply with the
15 availability of moneys and any limitations or directions
16 provided for in the General Appropriations Act or chapter 216.
17 If necessary to safeguard the state's systems of providing
18 services to elderly and disabled persons and subject to the
19 notice and review provisions of s. 216.177, the Governor may
20 direct the Agency for Health Care Administration to amend the
21 Medicaid state plan to delete the optional Medicaid service
22 known as "Intermediate Care Facilities for the Developmentally
23 Disabled." Optional services may include:
24 (13) HOME AND COMMUNITY-BASED SERVICES.--The agency
25 may pay for home-based or community-based services that are
26 rendered to a recipient in accordance with a federally
27 approved waiver program.
28 (a) The agency may limit or eliminate coverage for
29 certain ~~Project AIDS Care Waiver~~ services, preauthorize
30 high-cost or highly utilized services, or make any other
31 adjustments necessary to comply with any limitations or

1 directions provided for in the General Appropriations Act.
2 (b) The agency may consolidate types of services
3 offered in the Aged and Disabled Waiver, the Channeling
4 Waiver, Project AIDS Care Waiver, and the Traumatic Brain and
5 Spinal Cord Injury Waiver programs in order to group similar
6 services under a single service, or upon evidence of the need
7 for including a particular service type in a particular
8 waiver. The agency may seek federal waiver approval as
9 necessary to implement this policy.
10 (c) The agency may implement a utilization management
11 program designed to preauthorize home-and-community-based
12 service plans, including, but not limited to, proposed
13 quantity and duration of services, and to monitor ongoing
14 service use by participants in the program. The agency may
15 competitively procure a qualified organization to provide
16 utilization management of home-and-community-based services.
17 The agency may seek federal waiver approval as necessary to
18 implement this policy.
19 (14) HOSPICE CARE SERVICES.--The agency may pay for
20 all reasonable and necessary services for the palliation or
21 management of a recipient's terminal illness, if the services
22 are provided by a hospice that is licensed under part VI of
23 chapter 400 and meets Medicare certification requirements.
24 Effective October 1, 2004, subject to federal approval, the
25 community hospice income standard would be equal to the level
26 set in s. 409.904(1).
27 (15) INTERMEDIATE CARE FACILITY FOR THE
28 DEVELOPMENTALLY DISABLED SERVICES.--The agency may pay for
29 health-related care and services provided on a 24-hour-a-day
30 basis by a facility licensed and certified as a Medicaid
31 Intermediate Care Facility for the Developmentally Disabled,

1 for a recipient who needs such care because of a developmental
2 disability.
3 Section 8. Present subsection (8) of section 409.9065,
4 Florida Statutes, is redesignated as subsection (9), and a new
5 subsection (8) is added to that section, to read:
6 409.9065 Pharmaceutical expense assistance.--
7 (8) In the absence of state appropriations for the
8 expansion of the Lifesaver Rx Program to provide benefits to
9 higher income groups and additional discounts as described in
10 subsections (2) and (3), the Agency for Health Care
11 Administration may, subject to federal approval and continuing
12 state appropriations, operate a pharmaceutical expense
13 assistance program that limits eligibility and benefits to
14 Medicaid beneficiaries who do not normally receive Medicaid
15 benefits, are Florida residents age 65 and older, have an
16 income less than or equal to 120 percent of the federal
17 poverty level, are eligible for Medicare, and request to be
18 enrolled in the program. Benefits under the limited
19 pharmaceutical expense assistance program shall include
20 Medicaid payment for up to $160 per month for prescribed
21 drugs, subject to benefit utilization controls applied to
22 other Medicaid prescribed drug benefits and the following
23 copayments: $2 per generic product, $5 for a product that is
24 on the Medicaid Preferred Drug List, and $15 for a product
25 that is not on the Preferred Drug List.
26 Section 9. Subsection (12) is added to section
27 409.907, Florida Statutes, to read:
28 409.907 Medicaid provider agreements.--The agency may
29 make payments for medical assistance and related services
30 rendered to Medicaid recipients only to an individual or
31 entity who has a provider agreement in effect with the agency,

1 who is performing services or supplying goods in accordance
2 with federal, state, and local law, and who agrees that no
3 person shall, on the grounds of handicap, race, color, or
4 national origin, or for any other reason, be subjected to
5 discrimination under any program or activity for which the
6 provider receives payment from the agency.
7 (12) Licensed, certified, or otherwise qualified
8 providers are not entitled to enrollment in a Medicaid
9 provider network.
10 Section 10. Subsection (9) is added to section
11 409.911, Florida Statutes, to read:
12 409.911 Disproportionate share program.--Subject to
13 specific allocations established within the General
14 Appropriations Act and any limitations established pursuant to
15 chapter 216, the agency shall distribute, pursuant to this
16 section, moneys to hospitals providing a disproportionate
17 share of Medicaid or charity care services by making quarterly
18 Medicaid payments as required. Notwithstanding the provisions
19 of s. 409.915, counties are exempt from contributing toward
20 the cost of this special reimbursement for hospitals serving a
21 disproportionate share of low-income patients.
22 (9) The Agency for Health Care Administration shall
23 convene a Medicaid Disproportionate Share Council.
24 (a) The purpose of the council is to study and make
25 recommendations regarding:
26 1. The formula for the regular disproportionate share
27 program and alternative financing options;
28 2. Enhanced Medicaid funding through the Special
29 Medicaid Payment program; and
30 3. The federal status of the upper-payment-limit
31 funding option and how this option may be used to promote

1 health care initiatives determined by the council to be state
2 health care priorities.
3 (b) The council shall include representatives of the
4 Executive Office of the Governor and of the agency,
5 representatives from teaching, public, private nonprofit,
6 private for-profit, and family practice teaching hospitals,
7 and representatives from other groups as needed.
8 (c) The council shall submit its findings and
9 recommendations to the Governor and the Legislature no later
10 than February 1 of each year.
11 Section 11. Subsection (40) of section 409.912,
12 Florida Statutes, is amended, and subsection (45) is added to
13 that section, to read:
14 409.912 Cost-effective purchasing of health care.--The
15 agency shall purchase goods and services for Medicaid
16 recipients in the most cost-effective manner consistent with
17 the delivery of quality medical care. The agency shall
18 maximize the use of prepaid per capita and prepaid aggregate
19 fixed-sum basis services when appropriate and other
20 alternative service delivery and reimbursement methodologies,
21 including competitive bidding pursuant to s. 287.057, designed
22 to facilitate the cost-effective purchase of a case-managed
23 continuum of care. The agency shall also require providers to
24 minimize the exposure of recipients to the need for acute
25 inpatient, custodial, and other institutional care and the
26 inappropriate or unnecessary use of high-cost services. The
27 agency may establish prior authorization requirements for
28 certain populations of Medicaid beneficiaries, certain drug
29 classes, or particular drugs to prevent fraud, abuse, overuse,
30 and possible dangerous drug interactions. The Pharmaceutical
31 and Therapeutics Committee shall make recommendations to the

1 agency on drugs for which prior authorization is required. The
2 agency shall inform the Pharmaceutical and Therapeutics
3 Committee of its decisions regarding drugs subject to prior
4 authorization.
5 (40)(a) The agency shall implement a Medicaid
6 prescribed-drug spending-control program that includes the
7 following components:
8 1. Medicaid prescribed-drug coverage for brand-name
9 drugs for adult Medicaid recipients is limited to the
10 dispensing of four brand-name drugs per month per recipient.
11 Children are exempt from this restriction. Antiretroviral
12 agents are excluded from this limitation. No requirements for
13 prior authorization or other restrictions on medications used
14 to treat mental illnesses such as schizophrenia, severe
15 depression, or bipolar disorder may be imposed on Medicaid
16 recipients. Medications that will be available without
17 restriction for persons with mental illnesses include atypical
18 antipsychotic medications, conventional antipsychotic
19 medications, selective serotonin reuptake inhibitors, and
20 other medications used for the treatment of serious mental
21 illnesses. The agency shall also limit the amount of a
22 prescribed drug dispensed to no more than a 34-day supply. The
23 agency shall continue to provide unlimited generic drugs,
24 contraceptive drugs and items, and diabetic supplies. Although
25 a drug may be included on the preferred drug formulary, it
26 would not be exempt from the four-brand limit. The agency may
27 authorize exceptions to the brand-name-drug restriction based
28 upon the treatment needs of the patients, only when such
29 exceptions are based on prior consultation provided by the
30 agency or an agency contractor, but the agency must establish
31 procedures to ensure that:

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

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

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

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 14.25 ~~13.25~~ percent or wholesale acquisition cost plus 5 percent, whichever is less.

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

1 Medicaid drug benefit management program shall include
2 initiatives to manage drug therapies for HIV/AIDS patients,
3 patients using 20 or more unique prescriptions in a 180-day
4 period, and the top 1,000 patients in annual spending.
5 4. The agency may limit the size of its pharmacy
6 network based on need, competitive bidding, price
7 negotiations, credentialing, or similar criteria. The agency
8 shall give special consideration to rural areas in determining
9 the size and location of pharmacies included in the Medicaid
10 pharmacy network. A pharmacy credentialing process may include
11 criteria such as a pharmacy's full-service status, location,
12 size, patient educational programs, patient consultation,
13 disease-management services, and other characteristics. The
14 agency may impose a moratorium on Medicaid pharmacy enrollment
15 when it is determined that it has a sufficient number of
16 Medicaid-participating providers.
17 5. The agency shall develop and implement a program
18 that requires Medicaid practitioners who prescribe drugs to
19 use a counterfeit-proof prescription pad for Medicaid
20 prescriptions. The agency shall require the use of
21 standardized counterfeit-proof prescription pads by
22 Medicaid-participating prescribers or prescribers who write
23 prescriptions for Medicaid recipients. The agency may
24 implement the program in targeted geographic areas or
25 statewide.
26 6. The agency may enter into arrangements that require
27 manufacturers of generic drugs prescribed to Medicaid
28 recipients to provide rebates of at least 15.1 percent of the
29 average manufacturer price for the manufacturer's generic
30 products. These arrangements shall require that if a
31 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 12 ~~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 27 ~~25~~ percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Such other program benefits may include, but are not limited to,

disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek any federal waivers necessary to implement this initiative.

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

1 costs, the agency shall expand its current mail-order-pharmacy
2 diabetes-supply program to include all generic and brand-name
3 drugs used by Medicaid patients with diabetes. Medicaid
4 recipients in the current program may obtain nondiabetes drugs
5 on a voluntary basis. This initiative is limited to the
6 geographic area covered by the current contract. The agency
7 may seek ~~and implement~~ any federal waivers necessary to
8 implement this subparagraph.
9 10. The agency shall implement a
10 utilization-management and prior-authorization program for
11 COX-II selective inhibitor products. The program shall use
12 evidence-based therapy management guidelines to ensure medical
13 necessity and appropriate prescribing of COX-II products
14 versus conventional nonsteroidal anti-inflammatory agents
15 (NSAIDS) in the absence of contraindications regardless of
16 preferred drug list status. The agency may seek federal
17 waiver approval as necessary to implement this policy.
18 11. The agency shall limit to one dose per month any
19 drug prescribed for the purpose of enhancing or enabling
20 sexual performance. The agency may seek federal waiver
21 approval as necessary to implement this policy.
22 12. The agency may specify the preferred daily dosing
23 form or strength for the purpose of promoting best practices
24 with regard to the prescribing of certain drugs and ensuring
25 cost-effective prescribing practices.
26 13. The agency may require prior authorization for the
27 off-label use of Medicaid-covered prescribed drugs. The
28 agency may, but is not required to, preauthorize the use of a
29 product for an indication not in the approved labeling. Prior
30 authorization may require the prescribing professional to
31 provide information about the rationale and supporting medical

1 evidence for the off-label use of a drug.
2 14. The agency may adopt an algorithm-driven treatment
3 protocol for major psychiatric disorders, including, at a
4 minimum, schizophrenia, major depressive disorders, and
5 bipolar disorder. The purpose of the algorithms is to improve
6 the quality of care, achieve the best possible patient
7 outcomes, and ensure cost-effective management of the use of
8 medications. The medication program shall use evidence-based,
9 consensus medication treatment algorithms, clinical and
10 technical support necessary to aid clinician implementation of
11 the algorithm, patient and family education programs to ensure
12 that the patient is an active partner in care, and the uniform
13 documentation of care provided and patient outcomes achieved.
14 The agency shall coordinate the development and adoption of
15 medication algorithms with the Department of Children and
16 Family Services. The agency may seek any federal waivers
17 necessary to implement this program.
18 15. The agency shall implement a Medicaid behavioral
19 health drug management program financed through a value-added
20 agreement with pharmaceutical manufacturers that provide
21 financing for program startup and operational costs and
22 guarantee Medicaid budget savings. The agency shall contract
23 for the implementation of this program with vendors that have
24 an established relationship with pharmaceutical manufacturers
25 providing grant funds and experience in operating behavioral
26 health drug management programs. The agency, in conjunction
27 with the Department of Children and Family Services, shall
28 implement the Medicaid behavioral health drug management
29 system that is designed to improve the quality of care and
30 behavioral health prescribing practices based on best-practice
31 guidelines, improve patient adherence to medication plans,

1 reduce clinical risk, and lower prescribed drug costs and the
2 rate of inappropriate spending on Medicaid behavioral drugs.
3 The program must:
4 a. Provide for the development and adoption of
5 best-practice guidelines for behavioral-health-related drugs,
6 such as antipsychotics, antidepressants, and medications for
7 treating bipolar disorders and other behavioral conditions,
8 and translate them into practice; review behavioral health
9 prescribers and compare their prescribing patterns to a number
10 of indicators that are based on national standards; and
11 determine deviations from best-practice guidelines;
12 b. Implement processes for providing feedback to and
13 educating prescribers using best-practice educational
14 materials and peer-to-peer consultation;
15 c. Assess Medicaid beneficiaries who are outliers in
16 their use of behavioral health drugs with regard to the
17 numbers and types of drugs taken, drug dosages, combination
18 drug therapies, and other indicators of improper use of
19 behavioral health drugs;
20 d. Alert prescribers to patients who fail to refill
21 prescriptions in a timely fashion, are prescribed multiple
22 same-class behavioral health drugs, and may have other
23 potential medication problems;
24 e. Track spending trends for behavioral health drugs
25 and deviation from best-practice guidelines;
26 f. Use educational and technological approaches to
27 promote best practices; educate consumers; and train
28 prescribers in the use of practice guidelines;
29 g. Disseminate electronic and published materials;
30 h. Hold statewide and regional conferences; and
31 i. Implement a disease-management program with a model

1 quality-based medication component for severely mentally ill
2 individuals and emotionally disturbed children who are high
3 users of care.
4
5 If the agency is unable to negotiate a contract with one or
6 more manufacturers to finance and guarantee savings associated
7 with a behavioral health drug management program by July 30,
8 2004, the four-brand drug limit and preferred drug list
9 prior-authorization requirements shall apply to
10 mental-health-related drugs, notwithstanding any provision in
11 subparagraph 1.
12 (b) The agency shall implement this subsection to the
13 extent that funds are appropriated to administer the Medicaid
14 prescribed-drug spending-control program. The agency may
15 contract ~~all or~~ any part or all of this program, including the
16 overall management of the drug program, to private
17 organizations.
18 (c) The agency shall submit quarterly reports to the
19 Governor, the President of the Senate, and the Speaker of the
20 House of Representatives which must include, but need not be
21 limited to, the progress made in implementing this subsection
22 and its effect on Medicaid prescribed-drug expenditures.
23 (45) The agency may implement Medicaid fee-for-service
24 provider network controls, including, but not limited to,
25 provider credentialing. If a credentialing process is used,
26 the agency may limit its network based upon the following
27 considerations:
28 (a) Beneficiary access to care;
29 (b) Provider availability;
30 (c) Provider quality standards;
31 (d) Cultural competency;

1 (e) Demographic characteristics of beneficiaries;
2 (f) Practice standards;
3 (g) Service wait times;
4 (h) Usage criteria;
5 (i) Provider turnover;
6 (j) Provider profiling;
7 (k) Provider license history;
8 (l) History of fraud and abuse findings;
9 (m) Peer review;
10 (n) Policy and billing infractions;
11 (o) Clinical and medical record audit findings; and
12 (p) Such other findings as the agency considers
13 necessary to ensure the integrity of the program.
14 Section 12. Subsection (2) of section 409.9122,
15 Florida Statutes, is amended, and subsection (14) is added to
16 that section, to read:
17 409.9122 Mandatory Medicaid managed care enrollment;
18 programs and procedures.--
19 (2)(a) The agency shall enroll in a managed care plan
20 or MediPass all Medicaid recipients, except those Medicaid
21 recipients who are: in an institution; enrolled in the
22 Medicaid medically needy program; or eligible for both
23 Medicaid and Medicare. However, to the extent permitted by
24 federal law, the agency may enroll in a managed care plan or
25 MediPass a Medicaid recipient who is exempt from mandatory
26 managed care enrollment, provided that:
27 1. The recipient's decision to enroll in a managed
28 care plan or MediPass is voluntary;
29 2. If the recipient chooses to enroll in a managed
30 care plan, the agency has determined that the managed care
31 plan provides specific programs and services which address the

1 special health needs of the recipient; and
2 3. The agency receives any necessary waivers from the
3 federal Health Care Financing Administration.
4
5 The agency shall develop rules to establish policies by which
6 exceptions to the mandatory managed care enrollment
7 requirement may be made on a case-by-case basis. The rules
8 shall include the specific criteria to be applied when making
9 a determination as to whether to exempt a recipient from
10 mandatory enrollment in a managed care plan or MediPass.
11 School districts participating in the certified school match
12 program pursuant to ss. 409.908(21) and 1011.70 shall be
13 reimbursed by Medicaid, subject to the limitations of s.
14 1011.70(1), for a Medicaid-eligible child participating in the
15 services as authorized in s. 1011.70, as provided for in s.
16 409.9071, regardless of whether the child is enrolled in
17 MediPass or a managed care plan. Managed care plans shall make
18 a good faith effort to execute agreements with school
19 districts regarding the coordinated provision of services
20 authorized under s. 1011.70. County health departments
21 delivering school-based services pursuant to ss. 381.0056 and
22 381.0057 shall be reimbursed by Medicaid for the federal share
23 for a Medicaid-eligible child who receives Medicaid-covered
24 services in a school setting, regardless of whether the child
25 is enrolled in MediPass or a managed care plan. Managed care
26 plans shall make a good faith effort to execute agreements
27 with county health departments regarding the coordinated
28 provision of services to a Medicaid-eligible child. To ensure
29 continuity of care for Medicaid patients, the agency, the
30 Department of Health, and the Department of Education shall
31 develop procedures for ensuring that a student's managed care

1 plan or MediPass provider receives information relating to
2 services provided in accordance with ss. 381.0056, 381.0057,
3 409.9071, and 1011.70.
4 (b) A Medicaid recipient shall not be enrolled in or
5 assigned to a managed care plan or MediPass unless the managed
6 care plan or MediPass has complied with the quality-of-care
7 standards specified in paragraphs (3)(a) and (b),
8 respectively.
9 (c) Medicaid recipients shall have a choice of managed
10 care plans or MediPass. The Agency for Health Care
11 Administration, the Department of Health, the Department of
12 Children and Family Services, and the Department of Elderly
13 Affairs shall cooperate to ensure that each Medicaid recipient
14 receives clear and easily understandable information that
15 meets the following requirements:
16 1. Explains the concept of managed care, including
17 MediPass.
18 2. Provides information on the comparative performance
19 of managed care plans and MediPass in the areas of quality,
20 credentialing, preventive health programs, network size and
21 availability, and patient satisfaction.
22 3. Explains where additional information on each
23 managed care plan and MediPass in the recipient's area can be
24 obtained.
25 4. Explains that recipients have the right to choose
26 their own managed care plans or MediPass. However, if a
27 recipient does not choose a managed care plan or MediPass, the
28 agency will assign the recipient to a managed care plan or
29 MediPass according to the criteria specified in this section.
30 5. Explains the recipient's right to complain, file a
31 grievance, or change managed care plans or MediPass providers

1 if the recipient is not satisfied with the managed care plan
2 or MediPass.
3 (d) The agency shall develop a mechanism for providing
4 information to Medicaid recipients for the purpose of making a
5 managed care plan or MediPass selection. Examples of such
6 mechanisms may include, but not be limited to, interactive
7 information systems, mailings, and mass marketing materials.
8 Managed care plans and MediPass providers are prohibited from
9 providing inducements to Medicaid recipients to select their
10 plans or from prejudicing Medicaid recipients against other
11 managed care plans or MediPass providers.
12 (e) Medicaid recipients who are already enrolled in a
13 managed care plan or MediPass shall be offered the opportunity
14 to change managed care plans or MediPass providers on a
15 staggered basis, as defined by the agency. All Medicaid
16 recipients shall have 90 days in which to make a choice of
17 managed care plans or MediPass providers. Those Medicaid
18 recipients who do not make a choice shall be assigned to a
19 managed care plan or MediPass in accordance with paragraph
20 (f). To facilitate continuity of care, for a Medicaid
21 recipient who is also a recipient of Supplemental Security
22 Income (SSI), prior to assigning the SSI recipient to a
23 managed care plan or MediPass, the agency shall determine
24 whether the SSI recipient has an ongoing relationship with a
25 MediPass provider or managed care plan, and if so, the agency
26 shall assign the SSI recipient to that MediPass provider or
27 managed care plan. Those SSI recipients who do not have such a
28 provider relationship shall be assigned to a managed care plan
29 or MediPass provider in accordance with paragraph (f).
30 (f) When a Medicaid recipient does not choose a
31 managed care plan or MediPass provider, the agency shall

assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 39 ~~40~~ percent in MediPass and 61 ~~60~~ percent in managed care plans is achieved. Once this enrollment is achieved, the assignments of recipients who fail to make a choice shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 39 ~~40~~ percent and 61 ~~60~~ percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(3)(g), Children's Medical Services network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services network, and pediatric

1 emergency department diversion programs authorized by this
2 chapter or the General Appropriations Act. When making
3 assignments, the agency shall take into account the following
4 criteria and considerations:
5 1. A managed care plan has sufficient network capacity
6 to meet the need of members.
7 2. The managed care plan or MediPass has previously
8 enrolled the recipient as a member, or one of the managed care
9 plan's primary care providers or MediPass providers has
10 previously provided health care to the recipient.
11 3. The agency has knowledge that the member has
12 previously expressed a preference for a particular managed
13 care plan or MediPass provider as indicated by Medicaid
14 fee-for-service claims data, but has failed to make a choice.
15 4. The managed care plan's or MediPass primary care
16 providers are geographically accessible to the recipient's
17 residence.
18
19 ~~(g)~~ When more than one managed care plan or MediPass provider
20 meets the criteria specified in this paragraph~~(f)~~, the agency
21 shall make recipient assignments consecutively by family unit.
22 (g)~~(h)~~ The agency may not engage in practices that are
23 designed to favor one managed care plan over another or that
24 are designed to influence Medicaid recipients to enroll in
25 MediPass rather than in a managed care plan or to enroll in a
26 managed care plan rather than in MediPass. This subsection
27 does not prohibit the agency from reporting on the performance
28 of MediPass or any managed care plan, as measured by
29 performance criteria developed by the agency.
30 (h) Effective January 1, 2005, the agency and the
31 Department of Children and Family Services shall ensure that

1 applicants for Medicaid for categories of assistance that
2 require eligible applicants to enroll in managed care shall
3 choose or be assigned to a managed care plan prior to an
4 eligibility start date so that enrollment in a managed care
5 plan begins on the same day as the eligibility start date.
6 (i) After a recipient has made a selection or has been
7 enrolled in a managed care plan or MediPass, the recipient
8 shall have 90 days in which to voluntarily disenroll and
9 select another managed care plan or MediPass provider. After
10 90 days, no further changes may be made except for cause.
11 Cause shall include, but not be limited to, poor quality of
12 care, lack of access to necessary specialty services, an
13 unreasonable delay or denial of service, or fraudulent
14 enrollment. The agency shall develop criteria for good cause
15 disenrollment for chronically ill and disabled populations who
16 are assigned to managed care plans if more appropriate care is
17 available through the MediPass program. The agency must make
18 a determination as to whether cause exists. However, the
19 agency may require a recipient to use the managed care plan's
20 or MediPass grievance process prior to the agency's
21 determination of cause, except in cases in which immediate
22 risk of permanent damage to the recipient's health is alleged.
23 The grievance process, when utilized, must be completed in
24 time to permit the recipient to disenroll no later than the
25 first day of the second month after the month the
26 disenrollment request was made. If the managed care plan or
27 MediPass, as a result of the grievance process, approves an
28 enrollee's request to disenroll, the agency is not required to
29 make a determination in the case. The agency must make a
30 determination and take final action on a recipient's request
31 so that disenrollment occurs no later than the first day of

the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

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

(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 39 ~~40~~ percent in MediPass and 61 ~~60~~ percent in managed care plans is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 39 ~~40~~ percent and 61 ~~60~~ percent proportion, respectively. In

1 geographic areas where the agency is contracting for the
2 provision of comprehensive behavioral health services through
3 a capitated prepaid arrangement, recipients who fail to make a
4 choice shall be assigned equally to MediPass or a managed care
5 plan. For purposes of this paragraph, when referring to
6 assignment, the term "managed care plans" includes exclusive
7 provider organizations, provider service networks, Children's
8 Medical Services network, minority physician networks, and
9 pediatric emergency department diversion programs authorized
10 by this chapter or the General Appropriations Act. When making
11 assignments, the agency shall take into account the following
12 criteria:
13 1. A managed care plan has sufficient network capacity
14 to meet the need of members.
15 2. The managed care plan or MediPass has previously
16 enrolled the recipient as a member, or one of the managed care
17 plan's primary care providers or MediPass providers has
18 previously provided health care to the recipient.
19 3. The agency has knowledge that the member has
20 previously expressed a preference for a particular managed
21 care plan or MediPass provider as indicated by Medicaid
22 fee-for-service claims data, but has failed to make a choice.
23 4. The managed care plan's or MediPass primary care
24 providers are geographically accessible to the recipient's
25 residence.
26 5. The agency has authority to make mandatory
27 assignments based on quality of service and performance of
28 managed care plans.
29 (l) Notwithstanding the provisions of chapter 287, the
30 agency may, at its discretion, renew cost-effective contracts
31 for choice counseling services once or more for such periods

as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.

(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 as needed to implement this adjustment.

Section 13. Paragraph (b) of subsection (1) of section 430.204, Florida Statutes, is amended to read:

430.204 Community-care-for-the-elderly core services; departmental powers and duties.--

(1)

(b) ~~For fiscal year 2003-2004 only,~~ The department shall fund, through each area agency on aging in each county as defined in s. 125.011(1), more than one community care service system the primary purpose of which is the prevention of unnecessary institutionalization of functionally impaired elderly persons through the provision of community-based core services. ~~This paragraph expires July 1, 2004.~~

Section 14. Paragraph (b) of subsection (1) of section 430.205, Florida Statutes, is amended to read:

430.205 Community care service system.--

(1)

(b) ~~For fiscal year 2003-2004 only,~~ The department shall fund, through the area agency on aging in each county as defined in s. 125.011(1), more than one community care service system that provides case management and other in-home and

community services as needed to help elderly persons maintain independence and prevent or delay more costly institutional care. ~~This paragraph expires July 1, 2004.~~

Section 15. Subsection (3) and paragraph (b) of subsection (5) of section 624.91, Florida Statutes, as amended by CS for SB 2000, 1st Engrossed, are amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

~~(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.--Only the following individuals are eligible for state-funded assistance in paying Florida Healthy Kids premiums:~~

~~(a) Residents of this state who are eligible for the Florida KidCare program pursuant to s. 409.814.~~

~~(b) Notwithstanding s. 409.814, legal aliens who are enrolled in the Florida Healthy Kids program as of January 31, 2004, who do not qualify for Title XXI federal funds because they are not qualified aliens as defined in s. 409.811.~~

~~(c) Notwithstanding s. 409.814, individuals who have attained the age of 19 as of March 31, 2004, who were receiving Florida Healthy Kids benefits prior to the enactment of the Florida KidCare program. This paragraph shall be repealed March 31, 2005.~~

~~(d) Notwithstanding s. 409.814, state employee dependents who were enrolled in the Florida Healthy Kids program as of January 31, 2004. Such individuals shall remain eligible until January 1, 2005.~~

(4)~~(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

1 for the actual or estimated administrative expenses.
2 2. Arrange for the collection of any voluntary
3 contributions to provide for payment of premiums for children
4 who are not eligible for medical assistance under Title XXI of
5 the Social Security Act. Each fiscal year, the corporation
6 shall establish a local match policy for the enrollment of
7 non-Title-XXI-eligible children in the Healthy Kids program.
8 By May 1 of each year, the corporation shall provide written
9 notification of the amount to be remitted to the corporation
10 for the following fiscal year under that policy. Local match
11 sources may include, but are not limited to, funds provided by
12 municipalities, counties, school boards, hospitals, health
13 care providers, charitable organizations, special taxing
14 districts, and private organizations. The minimum local match
15 cash contributions required each fiscal year and local match
16 credits shall be determined by the General Appropriations Act.
17 The corporation shall calculate a county's local match rate
18 based upon that county's percentage of the state's total
19 non-Title-XXI expenditures as reported in the corporation's
20 most recently audited financial statement. In awarding the
21 local match credits, the corporation may consider factors
22 including, but not limited to, population density, per capita
23 income, and existing child-health-related expenditures and
24 services.
25 3. Subject to the provisions of s. 409.8134, accept
26 voluntary supplemental local match contributions that comply
27 with the requirements of Title XXI of the Social Security Act
28 for the purpose of providing additional coverage in
29 contributing counties under Title XXI.
30 4. Establish the administrative and accounting
31 procedures for the operation of the corporation.

1 5. Establish, with consultation from appropriate
2 professional organizations, standards for preventive health
3 services and providers and comprehensive insurance benefits
4 appropriate to children, provided that such standards for
5 rural areas shall not limit primary care providers to
6 board-certified pediatricians.
7 6. Determine eligibility for children seeking to
8 participate in the Title XXI-funded components of the Florida
9 KidCare program consistent with the requirements specified in
10 s. 409.814, as well as the non-Title-XXI-eligible children as
11 provided in subsection (3).
12 7. Establish procedures under which providers of local
13 match to, applicants to and participants in the program may
14 have grievances reviewed by an impartial body and reported to
15 the board of directors of the corporation.
16 8. Establish participation criteria and, if
17 appropriate, contract with an authorized insurer, health
18 maintenance organization, or third-party administrator to
19 provide administrative services to the corporation.
20 9. Establish enrollment criteria which shall include
21 penalties or waiting periods of not fewer than 60 days for
22 reinstatement of coverage upon voluntary cancellation for
23 nonpayment of family premiums.
24 10. Contract with authorized insurers or any provider
25 of health care services, meeting standards established by the
26 corporation, for the provision of comprehensive insurance
27 coverage to participants. Such standards shall include
28 criteria under which the corporation may contract with more
29 than one provider of health care services in program sites.
30 Health plans shall be selected through a competitive bid
31 process. The Florida Healthy Kids Corporation shall purchase

1 goods and services in the most cost-effective manner
2 consistent with the delivery of quality and accessible medical
3 care. The maximum administrative cost for a Florida Healthy
4 Kids Corporation contract shall be 15 percent. The minimum
5 medical loss ratio for a Florida Healthy Kids Corporation
6 contract shall be 85 percent. The health plan selection
7 criteria and scoring system, and the scoring results, shall be
8 available upon request for inspection after the bids have been
9 awarded.
10 11. Establish disenrollment criteria in the event
11 local matching funds are insufficient to cover enrollments.
12 12. Develop and implement a plan to publicize the
13 Florida Healthy Kids Corporation, the eligibility requirements
14 of the program, and the procedures for enrollment in the
15 program and to maintain public awareness of the corporation
16 and the program.
17 13. Secure staff necessary to properly administer the
18 corporation. Staff costs shall be funded from state and local
19 matching funds and such other private or public funds as
20 become available. The board of directors shall determine the
21 number of staff members necessary to administer the
22 corporation.
23 14. Provide a report annually to the Governor, Chief
24 Financial Officer, Commissioner of Education, Senate
25 President, Speaker of the House of Representatives, and
26 Minority Leaders of the Senate and the House of
27 Representatives.
28 15. Establish benefit packages that ~~which~~ conform to
29 the provisions of the Florida KidCare program, as created in
30 ss. 409.810-409.820.
31 Section 16. This act shall take effect July 1, 2004,

1 except that this section and section 2 of this act shall take
2 effect May 1, 2004, or upon becoming a law, whichever occurs
3 later, in which case section 2 of this act shall operate
4 retroactive to May 1, 2004.
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7 =============== T I T L E A M E N D M E N T ===============
8 And the title is amended as follows:
9 Delete everything before the enacting clause
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11 and insert:
12 A bill to be entitled
13 An act relating to health care; amending s.
14 216.341, F.S.; clarifying that certain
15 provisions relate to the disbursement of trust
16 funds of the Department of Health, not county
17 health department trust funds; providing that
18 certain limitations on the number of authorized
19 positions do not apply to positions in the
20 Department of Health funded by specified
21 sources; amending s. 400.23, F.S.; reducing the
22 nursing home staffing requirement for certified
23 nursing assistants; amending s. 409.814, F.S.,
24 as amended, relating to eligibility for the
25 Florida KidCare program; providing that a child
26 who is otherwise disqualified based on a
27 preexisting medical condition shall be eligible
28 when enrollment is possible; amending s.
29 409.903, F.S.; amending income levels that
30 determine the eligibility of pregnant women and
31 children under 1 year of age for mandatory

1 medical assistance; amending s. 409.904, F.S.;
2 clarifying Medicaid recipients' responsibility
3 for the cost of nursing home care; providing
4 limitations on the care available to certain
5 persons under "medically needy" coverage;
6 amending income levels that determine the
7 eligibility of children under 1 year of age for
8 optional medical assistance; amending s.
9 409.905, F.S.; deleting an obsolete reference;
10 establishing a utilization-management program
11 for private duty nursing for children and
12 hospital neonatal intensive-care stays;
13 establishing a hospitalist program; eliminating
14 transportation services for nondisabled
15 beneficiaries; authorizing the Agency for
16 Health Care Administration to contract for
17 transportation services; amending s. 409.906,
18 F.S.; allowing the consolidation of certain
19 services; authorizing the implementation of a
20 home-based and community-based services
21 utilization-management program; specifying the
22 income standard for hospice care; amending s.
23 409.9065, F.S.; allowing the Agency for Health
24 Care Administration to operate a limited
25 pharmaceutical expense assistance program under
26 specified conditions; providing limitations on
27 benefits under the program; providing for
28 copayments; amending s. 409.907, F.S.;
29 clarifying that Medicaid provider network
30 status is not an entitlement; amending s.
31 409.911, F.S.; establishing the Medicaid

1 Disproportionate Share Council; amending s.
2 409.912, F.S.; reducing payment for
3 pharmaceutical ingredient prices; expanding the
4 existing pharmaceutical supplemental rebate
5 threshold to a minimum of 27 percent;
6 authorizing a return and reuse prescription
7 drug program; allowing for utilization
8 management and prior authorization for certain
9 categories of drugs; limiting allowable monthly
10 dosing of drugs that enhance or enable sexual
11 performance; modifying Medicaid prescribed drug
12 coverage to allow for preferred daily dosages
13 of certain select pharmaceuticals; authorizing
14 a prior-authorization program for the off-label
15 use of Medicaid prescribed pharmaceuticals;
16 adopting an algorithm-based treatment protocol
17 for select mental health disorders; requiring
18 the agency to implement a behavioral health
19 drug management program financed through an
20 agreement with pharmaceutical manufacturers;
21 providing contract requirements and program
22 requirements; providing for application of
23 certain drug limits and prior-authorization
24 requirements if the agency is unable to
25 negotiate a contract; allowing for limitation
26 of the Medicaid provider networks; amending s.
27 409.9122, F.S.; revising prerequisites to
28 mandatory assignment; specifying managed care
29 enrollment in certain areas of the state;
30 requiring certain Medicaid applicants to select
31 a managed care plan at the time of application;

1 eliminating the exclusion of special hospital
2 payments from rates for health maintenance
3 organizations; providing technical updates;
4 amending ss. 430.204 and 430.205, F.S.;
5 rescinding the expiration of certain funding
6 provisions relating to
7 community-care-for-the-elderly core services
8 and to the community care service system;
9 amending s. 624.91, F.S., the Florida Healthy
10 Kids Corporation Act; deleting certain
11 eligibility requirements for state-funded
12 assistance in paying premiums for the Florida
13 Healthy Kids program; requiring purchases to be
14 made in a manner consistent with delivering
15 accessible medical care; providing an effective
16 date.
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