Bill No. HB 1843, 1st Eng.

Amendment No. ___ Barcode 822742

CHAMBER ACTION

Senate	House
1/RE/3R 04/08/2004 02:00 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

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 each set of ~~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 3. Section 409.814, Florida Statutes, as amended by CS for SB 2000, 1st engrossed, 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. A child who is otherwise eligible for KidCare and who has a preexisting condition that prevents coverage under another insurance plan as described in subsection (4) 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. 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.

(1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be enrolled in Medicaid and is not eligible to receive health benefits under any other health benefits coverage authorized under the Florida KidCare program.

(2) A child who is not eligible for Medicaid, but who is eligible for the Florida KidCare program, may obtain health benefits coverage under any of the other components listed in s. 409.813 if such coverage is approved and available in the county in which the child resides. However, a child who is eligible for Medikids may participate in the Florida Healthy Kids program only if the child has a sibling participating in the Florida Healthy Kids program and the child's county of residence permits such enrollment.

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

(4) The following children are not eligible to receive premium assistance for health benefits coverage under 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:

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

(b) A child who is currently eligible for or covered under a family member's group health benefit plan or under other employer health insurance coverage, excluding coverage provided under the Florida Healthy Kids Corporation as

established under s. 624.91, provided that the cost of the child's participation is not greater than 5 percent of the family's income. This provision shall be applied during redetermination for children who were enrolled prior to July 1, 2004. These enrollees shall have 6 months of eligibility following redetermination to allow for a transition to the other health benefit plan.

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

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

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

(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 January 31, 2004.

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

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

(b) The agency is authorized to place limits on enrollment in Medikids by these children in order to avoid

adverse selection. The number of children participating in Medikids whose family income exceeds 200 percent of the federal poverty level must not exceed 10 percent of total enrollees in the Medikids program.

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

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

(6) Once a child is enrolled in the Florida KidCare program, the child is eligible for coverage under the program for 6 months without a redetermination or reverification of eligibility, if the family continues to pay the applicable premium. 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.

(7) When determining or reviewing a child's eligibility under the Florida KidCare program, the applicant shall be provided with reasonable notice of changes in

eligibility which may affect enrollment in one or more of the program components. When a transition from one program component to another is authorized, there shall be cooperation between the program components and the affected family which promotes continuity of health care coverage. Any authorized transfers must be managed within the program's overall appropriated or authorized levels of funding. Each component of the program shall establish a reserve to ensure that transfers between components will be accomplished within current year appropriations. These reserves shall be reviewed by each convening of the Social Services Estimating Conference to determine the adequacy of such reserves to meet actual experience.

(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.

(b) A statement from all family members that:

1. Their employer does not sponsor a health benefit plan for employees; or

2. The potential enrollee is not covered by the employer-sponsored health benefit plan because the potential enrollee is not eligible for coverage, or, if the potential enrollee is eligible but not covered, a statement of the cost to enroll the potential enrollee in the employer-sponsored health benefit plan.

(9) Subject to paragraph (4)(b) and s. 624.91(3), the Florida KidCare program shall withhold benefits from an enrollee if the program obtains evidence that the enrollee is no longer eligible, submitted incorrect or fraudulent information in order to establish eligibility, or failed to provide verification of eligibility. The applicant or enrollee shall be notified that because of such evidence program benefits will be withheld unless the applicant or enrollee contacts a designated representative of the program by a specified date, which must be within 10 days after the date of notice, to discuss and resolve the matter. The program shall make every effort to resolve the matter within a timeframe that will not cause benefits to be withheld from an eligible enrollee.

(10) The following individuals may be subject to prosecution in accordance with s. 414.39:

(a) An applicant obtaining or attempting to obtain benefits for a potential enrollee under the Florida KidCare program when the applicant knows or should have known the potential enrollee does not qualify for the Florida KidCare program.

(b) An individual who assists an applicant in obtaining or attempting to obtain benefits for a potential enrollee under the Florida KidCare program when the individual knows or should have known the potential enrollee does not qualify for the Florida KidCare program.

Section 4. 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) Effective October 1, 2004, 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.

Section 5. Subsections (2), (3), and (8) 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. Children and pregnant women ~~A family or person~~ eligible under the coverage known as the "medically needy~~,~~" are ~~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 January 1, 2005, parents or caretaker relatives of children eligible under the coverage known as "medically needy" and aged, blind, or disabled persons eligible under such coverage are limited to pharmacy 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.

(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

staff of the facility in which the anesthetic service is performed. Reimbursement for such services must be provided in an amount that equals not less than 80 percent of the reimbursement to a physician who provides the same services, unless otherwise provided for in the General Appropriations Act.

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

(3) FAMILY PLANNING SERVICES.--The agency shall pay for services necessary to enable a recipient voluntarily to plan family size or to space children. These services include information; education; counseling regarding the availability, benefits, and risks of each method of pregnancy prevention; drugs and supplies; and necessary medical care and followup. Each recipient participating in the family planning portion of the Medicaid program must be provided freedom to choose any alternative method of family planning, as required by federal law.

(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) 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

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, subject to federal Medicaid waiver approval, the agency may pay for ~~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 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

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) Effective September 1, 2004, the agency shall implement a hospitalist program in certain high-volume participating hospitals, in 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 beneficiaries with the hospitalist. The agency may competitively bid a contract for selection of a qualified organization to provide hospitalist services. The agency may seek federal waiver approval as necessary to implement this policy.

(e) Effective November 1, 2004, the agency shall implement a comprehensive utilization management program for

hospital neonatal intensive care stays in certain high-volume Medicaid participating hospitals, in select counties or statewide, and shall replace existing hospital inpatient utilization management programs. 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 may seek federal waiver approval as necessary to implement this policy.

(6) HOSPITAL OUTPATIENT SERVICES.--The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,500 per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

(7) INDEPENDENT LABORATORY SERVICES.--The agency shall pay for medically necessary diagnostic laboratory procedures ordered by a licensed physician or other licensed practitioner of the healing arts which are provided for a recipient in a laboratory that meets the requirements for Medicare participation and is licensed under chapter 483, if required.

(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.

(9) PHYSICIAN SERVICES.--The agency shall pay for covered services and procedures rendered to a recipient by, or under the personal supervision of, a person licensed under state law to practice medicine or osteopathic medicine. These services may be furnished in the physician's office, the Medicaid recipient's home, a hospital, a nursing facility, or elsewhere, but shall be medically necessary for the treatment of an injury, illness, or disease within the scope of the practice of medicine or osteopathic medicine as defined by state law. The agency shall not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.

(10) PORTABLE X-RAY SERVICES.--The agency shall pay for professional and technical portable radiological services ordered by a licensed physician or other licensed practitioner of the healing arts which are provided by a licensed professional in a setting other than a hospital, clinic, or office of a physician or practitioner of the healing arts, on

behalf of a recipient.

(11) RURAL HEALTH CLINIC SERVICES.--The agency shall pay for outpatient primary health care services for a recipient provided by a clinic certified by and participating in the Medicare program which is located in a federally designated, rural, medically underserved area and has on its staff one or more licensed primary care nurse practitioners or physician assistants, and a licensed staff supervising physician or a consulting supervising physician.

(12) TRANSPORTATION SERVICES.--The agency shall ensure that appropriate transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for medically necessary and Medicaid-compensable services, provided a recipient's ~~client's~~ ability to choose a specific transportation provider is ~~shall be~~ limited to those options resulting from policies established by the agency to meet the fiscal limitations of the General Appropriations Act. Effective January 1, 2005, except for persons who meet Medicaid disability standards adopted by rule, nonemergency transportation services may not be offered to nondisabled recipients if public transportation is generally available in the beneficiary's community. The agency may pay for transportation and other related travel expenses as necessary only if these services are not otherwise available. The agency may competitively bid and contract with a statewide vendor on a capitated basis for the provision of nonemergency transportation services. The agency may seek federal waiver approval as necessary to implement this subsection.

Section 7. Subsections (13), (14), 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:

(13) HOME AND COMMUNITY-BASED SERVICES.--The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program.

(a) 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, 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 upon evidence of the need for including a particular service type in a particular waiver. The agency may seek federal waiver approval as necessary to implement this policy.

(c) The agency may implement a utilization management program designed to preauthorize home-and-community-based service plans, including, but not limited to, proposed quantity and duration of services, and to monitor ongoing service use by participants in the program. The agency may competitively procure a qualified organization to provide utilization management of home-and-community-based services. The agency may seek federal waiver approval as necessary to implement this policy.

(14) HOSPICE CARE SERVICES.--The agency may pay for all reasonable and necessary services for the palliation or management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under part VI of chapter 400 and meets Medicare certification requirements. Effective October 1, 2004, subject to federal approval, the community hospice income standard would be equal to the level set in s. 409.904(1).

(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.

Section 8. Present subsection (8) of section 409.9065, Florida Statutes, is redesignated as subsection (9), and a new subsection (8) is added to that section, to read:

409.9065 Pharmaceutical expense assistance.--

(8) In the absence of state appropriations for the expansion of 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 9. 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 10. Subsection (9) is added to section 409.911, Florida Statutes, 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.

(9) The Agency for Health Care Administration shall convene 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; and

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 11. Subsection (40) of section 409.912, Florida Statutes, is amended, and subsection (45) is added to that section, 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.

(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 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

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 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

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 implement a utilization-management and prior-authorization program for COX-II selective inhibitor products. The program shall use evidence-based therapy management guidelines to ensure medical necessity and appropriate prescribing of COX-II products versus conventional nonsteroidal anti-inflammatory agents (NSAIDS) in the absence of contraindications regardless of preferred drug list status. The agency may seek federal waiver approval as necessary to implement this policy.

11. The agency shall limit to one dose per month any drug prescribed for the purpose of enhancing or enabling sexual performance. The agency may seek federal waiver approval as necessary to implement this policy.

12. 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 and ensuring cost-effective prescribing practices.

13. The agency may require prior authorization for the off-label use of Medicaid-covered prescribed drugs. 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.

14. The agency may adopt an algorithm-driven treatment protocol for major psychiatric disorders, including, at a minimum, schizophrenia, major depressive disorders, and bipolar disorder. The purpose of the algorithms is to improve the quality of care, achieve the best possible patient outcomes, and ensure cost-effective management of the use of medications. The medication program shall use evidence-based, consensus medication treatment algorithms, clinical and technical support necessary to aid clinician implementation of the algorithm, patient and family education programs to ensure that the patient is an active partner in care, and the uniform documentation of care provided and patient outcomes achieved. The agency shall coordinate the development and adoption of medication algorithms with the Department of Children and Family Services. The agency may seek any federal waivers necessary to implement this program.

15. The agency shall implement a Medicaid behavioral health drug management program financed through a value-added agreement with pharmaceutical manufacturers that provide financing for program startup and operational costs and guarantee Medicaid budget savings. The agency shall contract for the implementation of this program with vendors that have an established relationship with pharmaceutical manufacturers providing grant funds and experience in operating behavioral health drug management programs. The agency, in conjunction with the Department of Children and Family Services, shall implement the Medicaid behavioral health 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 must:

a. 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, and 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;

b. Implement processes for providing feedback to and educating prescribers using best-practice educational materials and peer-to-peer consultation;

c. 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;

d. 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;

e. Track spending trends for behavioral health drugs and deviation from best-practice guidelines;

f. Use educational and technological approaches to promote best practices; educate consumers; and train prescribers in the use of practice guidelines;

g. Disseminate electronic and published materials;

h. Hold statewide and regional conferences; and

i. 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.

If the agency is unable to negotiate a contract with one or more manufacturers to finance and guarantee savings associated with a behavioral health drug management program by July 30, 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.

(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 or all of this program, including the overall management of the drug 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.

(45) The agency may implement Medicaid fee-for-service provider network controls, including, but not limited to, provider credentialing. If a credentialing process is used, the agency may limit its network based upon the following considerations:

(a) Beneficiary access to care;

(b) Provider availability;

(c) Provider quality standards;

(d) Cultural competency;

(e) Demographic characteristics of beneficiaries;

(f) Practice standards;

(g) Service wait times;

(h) Usage criteria;

(i) Provider turnover;

(j) Provider profiling;

(k) Provider license history;

(l) History of fraud and abuse findings;

(m) Peer review;

(n) Policy and billing infractions;

(o) Clinical and medical record audit findings; and

(p) Such other findings as the agency considers necessary to ensure the integrity of the program.

Section 12. Subsection (2) of section 409.9122, Florida Statutes, is amended, and subsection (14) is added to that 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. 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.

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

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

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

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

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

4. Explains that recipients have the right to choose their own managed care plans or MediPass. However, if a recipient does not choose a managed care plan or MediPass, the agency will assign the recipient to a managed care plan or MediPass according to the criteria specified in this section.

5. Explains the recipient's right to complain, file a grievance, or change managed care plans or MediPass providers

if the recipient is not satisfied with the managed care plan or MediPass.

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

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

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall

assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 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

emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria and considerations:

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

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

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

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

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

(g)~~(h)~~ The agency may not engage in practices that are designed to favor one managed care plan over another or that are designed to influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

(h) Effective January 1, 2005, the agency and the Department of Children and Family Services shall ensure that

applicants for Medicaid for categories of assistance that require eligible applicants to enroll in managed care shall choose or be assigned to a managed care plan prior to an eligibility start date so that enrollment in a managed care plan begins on the same day as the eligibility start date.

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

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

(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

geographic areas where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

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

(l) Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew cost-effective contracts 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

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 and accessible medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. The minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. 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 that ~~which~~ conform to the provisions of the Florida KidCare program, as created in ss. 409.810-409.820.

Section 16. This act shall take effect July 1, 2004,

except that this section and section 2 of this act shall take effect May 1, 2004, or upon becoming a law, whichever occurs later, in which case section 2 of this act shall operate retroactive to May 1, 2004.

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

And the title is amended as follows:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to health care; amending s. 216.341, F.S.; clarifying that certain provisions relate to the disbursement of trust funds of the Department of Health, not county health department trust funds; providing that certain limitations on the number of authorized positions do not apply to positions in the Department of Health funded by specified sources; amending s. 400.23, F.S.; reducing the nursing home staffing requirement for certified nursing assistants; amending s. 409.814, F.S., as amended, relating to eligibility for the Florida KidCare program; providing that a child who is otherwise disqualified based on a preexisting medical condition shall be eligible when enrollment is possible; amending s. 409.903, F.S.; amending income levels that determine the eligibility of pregnant women and children under 1 year of age for mandatory

medical assistance; amending s. 409.904, F.S.; clarifying Medicaid recipients' responsibility for the cost of nursing home care; providing limitations on the care available to certain persons under "medically needy" coverage; amending income levels that determine the eligibility of children under 1 year of age for optional medical assistance; amending s. 409.905, F.S.; deleting an obsolete reference; establishing a utilization-management program for private duty nursing for children and hospital neonatal intensive-care stays; establishing a hospitalist program; eliminating transportation services for nondisabled beneficiaries; authorizing the Agency for Health Care Administration to contract for transportation services; amending s. 409.906, F.S.; allowing the consolidation of certain services; authorizing the implementation of a home-based and community-based services utilization-management program; specifying the income standard for hospice care; amending s. 409.9065, F.S.; allowing the Agency for Health Care Administration to operate a limited pharmaceutical expense assistance program under specified conditions; providing limitations on benefits under the program; providing for copayments; amending s. 409.907, F.S.; clarifying that Medicaid provider network status is not an entitlement; amending s. 409.911, F.S.; establishing the Medicaid

Disproportionate Share Council; amending s. 409.912, F.S.; reducing payment for pharmaceutical ingredient prices; expanding the existing pharmaceutical supplemental rebate threshold to a minimum of 27 percent; authorizing a return and reuse prescription drug program; allowing for utilization management and prior authorization for certain categories of drugs; limiting allowable monthly dosing of drugs that enhance or enable sexual performance; modifying Medicaid prescribed drug coverage to allow for preferred daily dosages of certain select pharmaceuticals; authorizing a prior-authorization program for the off-label use of Medicaid prescribed pharmaceuticals; adopting an algorithm-based treatment protocol for select mental health disorders; requiring the agency to implement a behavioral health drug management program financed through an agreement with pharmaceutical manufacturers; providing contract requirements and program requirements; providing for application of certain drug limits and prior-authorization requirements if the agency is unable to negotiate a contract; allowing for limitation of the Medicaid provider networks; amending s. 409.9122, F.S.; revising prerequisites to mandatory assignment; specifying managed care enrollment in certain areas of the state; requiring certain Medicaid applicants to select a managed care plan at the time of application;

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