By the Committees on Ways and Means; Health and Human Services Appropriations; and Senator Saunders

576-1869-05

A bill to be entitled

An act relating to health care; amending s. 400.23, F.S.; delaying provisions requiring a nursing home staffing increase; amending ss. 409.903, 409.904, F.S.; deleting certain limitations on services to the medically needy; amending s. 409.906, F.S., relating to optional Medicaid services; providing for adult denture services; repealing s. 409.9065, F.S., relating to pharmaceutical expense assistance; amending s. 409.908, F.S.; revising guidelines relating to reimbursement of Medicaid providers; amending ss. 409.9112, 409.9113, 409.9117, F.S., relating to the hospital disproportionate share program; deleting obsolete provisions; amending s. 409.91195, F.S.; revising provisions relating to the Medicaid Pharmaceutical and Therapeutics Committee and its duties with respect to developing a preferred drug list; amending s. 409.912, F.S.; revising the Medicaid prescribed drug spending control program; eliminating case management fees; directing the Agency for Health Care Administration to implement, and authorizing it to seek federal waivers for, the program of all-inclusive care for children; amending s. 409.9122, F.S.; revising a provision governing assignment to a managed care option for a Medicaid recipient who does not choose a plan or provider in certain geographic areas where the Agency for Health Care Administration

contracts for comprehensive behavioral health services; amending s. 409.9124, F.S.; requiring the Agency for Health Care Administration to publish managed care reimbursement rates annually; limiting the application of certain rates and rate reductions; providing effective dates.

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

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

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

(3)(a) The agency shall adopt rules providing ~~for the~~ minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning January 1, 2003, and increasing to 2.9 hours of direct care per resident per day beginning July 1, 2006 ~~2005~~. Beginning January 1, 2002, no facility shall staff below one certified nursing assistant per 20 residents, and a minimum licensed nursing staffing of 1.0 hour of direct resident care per resident per day but never below one licensed nurse per 40 residents. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing 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 toward 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 toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

Section 2. Subsection (5) of section 409.903, Florida Statutes, is amended to read:

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

subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(5) A pregnant woman for the duration of her pregnancy and for the postpartum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program. ~~Effective July 1, 2005, eligibility for Medicaid services is eliminated for women who have incomes above 150 percent of the most current federal poverty level.~~

Section 3. Subsections (1) and (2) 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.

(1)<u>(a) From July 1, 2005, through December 31, 2005,</u> a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of federal poverty level, and whose assets do not exceed established limitations.

(b) Effective January 1, 2006, and subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

(2) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled. ~~Effective July 1, 2005, the medically needy are eligible for prescribed drug services only.~~

Section 4. Paragraph (b) of subsection (1) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid

providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(1) ADULT DENTAL SERVICES.--

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

Section 5. Effective January 1, 2006, section 409.9065, Florida Statutes, is repealed.

Section 6. Paragraph (a) of subsection (1) and paragraph (b) of subsection (2) of section 409.908, Florida Statutes, are amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5), except for:

1. The raising of rate reimbursement caps, excluding rural hospitals.

2. Recognition of the costs of graduate medical education.

3. Other methodologies recognized in the General Appropriations Act.

~~4. Hospital inpatient rates shall be reduced by 6 percent effective July 1, 2001, and restored effective April 1, 2002.~~

During the years funds are transferred from the Department of Health, any reimbursement supported by such funds shall be subject to certification by the Department of Health that the hospital has complied with s. 381.0403. The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received from state entities or local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent that the identified local health care provider that is otherwise

entitled to and is contracted to receive such local funds is the benefactor under the state's Medicaid program as determined under the General Appropriations Act and pursuant to an agreement between the Agency for Health Care Administration and the local governmental entity. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form shall identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature no later than January 1, annually.

(2)

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. Changes of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The agency shall amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or

licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.

2. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care subcomponent of the per diem rate shall be limited by the cost-based class ceiling and may be limited by the target rate class ceiling, and the indirect care subcomponent shall be limited by the lower of the cost-based class ceiling, ~~by~~ the target rate class ceiling, or ~~by~~ the individual provider target. ~~The agency shall adjust the patient care component effective January 1, 2002. The cost to adjust the direct care subcomponent shall be net of the total funds previously allocated for the case mix add on. The agency shall make the required changes to the nursing home cost reporting forms to implement this requirement effective January 1, 2002.~~

3. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing administration, minimum data set ~~MDS~~, and care plan coordinators, staff development, and staffing coordinator.

4. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly

allocated to the direct care subcomponent from a home office or management company.

5. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

6. In order to offset the cost of general and professional liability insurance, the agency shall amend the plan to allow for interim rate adjustments to reflect increases in the cost of general or professional liability insurance for nursing homes. This provision shall be implemented to the extent existing appropriations are available.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

Section 7. Section 409.9112, Florida Statutes, is amended to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.--In addition to the payments

made under s. 409.911, the Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year 2005-2006 ~~2004-2005~~, the agency shall not distribute moneys under the regional perinatal intensive care centers disproportionate share program~~, except as noted in subsection (2)~~. ~~In the event the Centers for Medicare and Medicaid Services do not approve Florida's inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the regional perinatal intensive care centers disproportionate share program.~~

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

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

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

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

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

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

and criteria as the department and agency deem appropriate as specified by rule.

(b) Agree to provide information to the department and agency, in a form and manner to be prescribed by rule of the department and agency, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

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

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

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

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

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

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

(4) Hospitals which fail to comply with any of the conditions in subsection (3) or the applicable rules of the

department and agency shall not receive any payments under this section until full compliance is achieved. A hospital which is not in compliance in two or more consecutive quarters shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating regional perinatal intensive care center program hospitals.

Section 8. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year <u>2005-2006</u> ~~2004-2005~~, the agency shall not distribute moneys under the teaching hospital disproportionate share program~~, except as noted in subsection (2)~~. ~~In the event the Centers for Medicare and Medicaid Services do not approve Florida's inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the teaching hospital disproportionate share program.~~

(1) On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation

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

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

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

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs,

where the total is computed for all state statutory teaching hospitals.

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

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

(c) A service index that comprises three components:

1. The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Administration Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by

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

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

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

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

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

Section 9. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--For the state fiscal year 2005-2006 ~~2004-2005~~, the agency shall not distribute moneys under the primary care disproportionate share program~~, except as noted in subsection (2)~~. ~~In the event the Centers for Medicare and Medicaid Services do not approve Florida's inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the primary care disproportionate share program.~~

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

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

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise

covered by Medicaid or another program administered by a governmental entity, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.

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

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

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

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

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

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

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

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

Section 10. Section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.--There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency ~~for Health Care Administration~~ for the purpose of developing a Medicaid preferred drug list ~~formulary pursuant to 42 U.S.C. s. 1396r-8~~.

(1) The ~~Medicaid Pharmaceutical and Therapeutics~~ committee shall be comprised ~~as specified in 42 U.S.C. s. 1396r-8 and consist~~ of 11 members appointed by the Governor.

Four members shall be physicians, licensed under chapter 458; one member licensed under chapter 459; five members shall be pharmacists licensed under chapter 465; and one member shall be a consumer representative. The members shall be appointed to serve for terms of 2 years from the date of their appointment. Members may be appointed to more than one term. The agency ~~for Health Care Administration~~ shall serve as staff for the committee and assist them with all ministerial duties. The Governor shall ensure that at least some of the members of the ~~Medicaid Pharmaceutical and Therapeutics~~ committee represent Medicaid participating physicians and pharmacies serving all segments and diversity of the Medicaid population, and have experience in either developing or practicing under a preferred drug list ~~formulary~~. At least one of the members shall represent the interests of pharmaceutical manufacturers.

(2) Committee members shall select a chairperson and a vice chairperson each year from the committee membership.

(3) The committee shall meet at least quarterly and may meet at other times at the discretion of the chairperson and members. The committee shall comply with rules adopted by the agency, including notice of any meeting of the committee pursuant to the requirements of the Administrative Procedure Act.

(4) Upon recommendation of the ~~Medicaid Pharmaceutical and Therapeutics~~ committee, the agency shall adopt a preferred drug list as described in s. 409.912(39). To the extent feasible, the committee shall review all drug classes included on ~~in~~ the preferred drug list ~~formulary at least~~ every 12 months, and may recommend additions to and deletions from the preferred drug list ~~formulary~~, such that the preferred drug list ~~formulary~~ provides for medically appropriate drug

therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

~~(5) Except for mental health related drugs, antiretroviral drugs, and drugs for nursing home residents and other institutional residents, reimbursement of drugs not included in the formulary is subject to prior authorization.~~

(5)~~(6)~~ The agency ~~for Health Care Administration~~ shall publish and disseminate the preferred drug list ~~formulary~~ to all Medicaid providers in the state by Internet posting on the agency's website or in other media.

(6)~~(7)~~ The committee shall ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter, have an opportunity to present public testimony to the committee with information or evidence supporting inclusion of a product on the preferred drug list. Such public testimony shall occur prior to any recommendations made by the committee for inclusion or exclusion from the preferred drug list. Upon timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the ~~Medicaid Pharmaceutical and Therapeutics~~ committee at the next regularly scheduled meeting following 12 months of distribution of the drug to the general public. ~~To the extent possible, upon notice by a manufacturer the agency shall also schedule a product review for any new product at the next regularly scheduled Medicaid Pharmaceutical and Therapeutics Committee.~~

~~(8) Until the Medicaid Pharmaceutical and Therapeutics Committee is appointed and a preferred drug list adopted by~~

~~the agency, the agency shall use the existing voluntary preferred drug list adopted pursuant to s. 72, chapter 2000-367, Laws of Florida. Drugs not listed on the voluntary preferred drug list will require prior authorization by the agency or its contractor.~~

(7)~~(9)~~ The ~~Medicaid Pharmaceutical and Therapeutics~~ committee shall develop its preferred drug list recommendations by considering the clinical efficacy, safety, and cost-effectiveness of a product. ~~When the preferred drug formulary is adopted by the agency, if a product on the formulary is one of the first four brand name drugs used by a recipient in a month the drug shall not require prior authorization.~~

(8) Upon timely notice, the agency shall ensure that any therapeutic class of drugs which includes a drug that has been removed from distribution to the public by its manufacturer or the United States Food and Drug Administration or has been required to carry a black box warning label by the United States Food and Drug Administration because of safety concerns is reviewed by the committee at the next regularly scheduled meeting. After such review, the committee must recommend whether to retain the therapeutic class of drugs or subcategories of drugs within a therapeutic class on the preferred drug list and whether to institute prior authorization requirements necessary to ensure patient safety.

(9)~~(10)~~ The Medicaid Pharmaceutical and Therapeutics Committee may also make recommendations to the agency regarding the prior authorization of any prescribed drug covered by Medicaid.

(10)~~(11)~~ Medicaid recipients may appeal agency preferred drug formulary decisions using the Medicaid fair

hearing process administered by the Department of Children and Family Services.

Section 11. Paragraph (a) of subsection (39) and subsections (44) and (49) of section 409.912, Florida Statutes, are amended, and subsection (50) 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. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. 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 mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and

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

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

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred

drug list should include at least two products in a therapeutic class. Medicaid prescribed-drug coverage for ~~brand name drugs for adult~~ Medicaid recipients is limited to eight drugs per month ~~the dispensing of four brand name drugs per month per recipient~~. Prior authorization is required for all additional prescriptions above the eight-drug limit and must meet step therapy and preferred drug list listing requirements. ~~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 unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency is authorized to seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to implement this subparagraph. ~~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; and

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

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

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

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. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

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 <u>list as described in this subsection</u> ~~formulary in accordance with 42 U.S.C. s. 1396r-8~~, and, pursuant to the establishment of such <u>preferred drug list</u> ~~formulary~~, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 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 list ~~formulary~~. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list ~~formulary~~ by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Effective July 1, 2004, value-added programs as a substitution for supplemental rebates are prohibited. The agency is authorized to seek any federal waivers to implement this initiative.

~~8. The agency shall establish an advisory committee for the purposes of studying the feasibility of using a restricted drug formulary for nursing home residents and other institutionalized adults. The committee shall be comprised of seven members appointed by the Secretary of Health Care Administration. The committee members shall include two physicians licensed under chapter 458 or chapter 459; three pharmacists licensed under chapter 465 and appointed from a list of recommendations provided by the Florida Long Term Care Pharmacy Alliance; and two pharmacists licensed under chapter 465.~~

8.~~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.

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

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

b. The agency, in conjunction with the Department of Children and Family Services, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program shall include the following elements:

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

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

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

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

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

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

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

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

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

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

14. The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

15. The agency shall implement a step-therapy-prior authorization-approval process for medications excluded from the preferred drug list. Medications listed on the preferred

drug list must be used within the previous 12 months prior to the alternative medications that are not listed. The step-therapy-prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy-approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8).

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

(44) The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(h), whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency

shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31 of each year. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(49) The agency shall contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules.

(b) The agency shall reimburse each minority physician network as a fee-for-service provider, including the case management fee for primary care<u>, if any</u>, or as a capitated rate provider for Medicaid services. Any savings shall be shared with the minority physician networks pursuant to the contract.

(c) For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and

case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(d) The agency may apply for any federal waivers needed to implement this subsection.

(50) The agency shall implement a program of all-inclusive care for children. The program of all-inclusive care for children shall be established to provide in-home hospice-like support services to children diagnosed with a life-threatening illness and enrolled in the Children's Medical Services network to reduce hospitalizations as appropriate. The agency, in consultation with the Department of Health, may implement the program of all-inclusive care for children after obtaining approval from the Centers for Medicare and Medicaid Services.

Section 12. Paragraph (k) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

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

(2)

(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 40 percent in MediPass and 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 40 percent and 60 percent proportion, respectively. In service areas 1 and 6 of the Agency for Health Care Administration ~~geographic areas~~ where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

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

Section 13. Section 409.9124, Florida Statutes, is amended to read:

409.9124 Managed care reimbursement.--

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

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

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

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

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

(2)~~(3)~~ Each year prior to establishing new managed care rates, the agency shall review all prior year adjustments for changes in trend, and shall reduce or eliminate those adjustments which are not reasonable and which reflect policies or programs which are not in effect. In addition, the agency shall apply only those policy reductions applicable to the fiscal year for which the rates are being set, which can be accurately estimated and verified by an independent actuary, and which have been implemented prior to or will be implemented during the fiscal year. The agency shall pay rates at per-member, per-month averages that equal, but do not exceed, the amounts allowed for in the General Appropriations Act applicable to the fiscal year for which the rates will be in effect.

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

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

Section 14. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2005.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS for SB 404

- Revises guidelines for the direct care subcomponent for nursing home reimbursement.

- Requires equal assignment of recipients to MediPass or a managed care plan in service areas 1 and 6 where the agency is contracting for prepaid behavioral health services and requires the assignment of 40 percent MediPass and 60 percent managed care in all other areas of the state for recipients who fail to choose a plan at the time of enrollment.

- Requires the agency to include policy reductions when establishing managed care rates, and limits payments of managed care rates to the amounts allowed in the General Appropriations Act.