

Bill No. CS for CS for SB 838, 1st Eng.

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CHAMBER ACTION

Senate

House

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Senators Peaden, Carlton, Saunders, Atwater, Campbell, and Rich moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Section 409.912, Florida Statutes, is amended to read:

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

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1 prepaid per capita and prepaid aggregate fixed-sum basis
2 services when appropriate and other alternative service
3 delivery and reimbursement methodologies, including
4 competitive bidding pursuant to s. 287.057, designed to
5 facilitate the cost-effective purchase of a case-managed
6 continuum of care. The agency shall also require providers to
7 minimize the exposure of recipients to the need for acute
8 inpatient, custodial, and other institutional care and the
9 inappropriate or unnecessary use of high-cost services. The
10 agency shall contract with a vendor to monitor and evaluate
11 the clinical practice patterns of providers in order to
12 identify trends that are outside the normal practice patterns
13 of a provider's professional peers or the national guidelines
14 of a provider's professional association. The vendor must be
15 able to provide information and counseling to a provider whose
16 practice patterns are outside the norms, in consultation with
17 the agency, to improve patient care and reduce inappropriate
18 utilization. The agency may mandate prior authorization, drug
19 therapy management, or disease management participation for
20 certain populations of Medicaid beneficiaries, certain drug
21 classes, or particular drugs to prevent fraud, abuse, overuse,
22 and possible dangerous drug interactions. The Pharmaceutical
23 and Therapeutics Committee shall make recommendations to the
24 agency on drugs for which prior authorization is required. The
25 agency shall inform the Pharmaceutical and Therapeutics
26 Committee of its decisions regarding drugs subject to prior
27 authorization. The agency is authorized to limit the entities
28 it contracts with or enrolls as Medicaid providers by
29 developing a provider network through provider credentialing.
30 The agency may competitively bid single-source-provider
31 contracts if procurement of goods or services results in

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1 demonstrated cost savings to the state without limiting access
2 to care. The agency may limit its network based on the
3 assessment of beneficiary access to care, provider
4 availability, provider quality standards, time and distance
5 standards for access to care, the cultural competence of the
6 provider network, demographic characteristics of Medicaid
7 beneficiaries, practice and provider-to-beneficiary standards,
8 appointment wait times, beneficiary use of services, provider
9 turnover, provider profiling, provider licensure history,
10 previous program integrity investigations and findings, peer
11 review, provider Medicaid policy and billing compliance
12 records, clinical and medical record audits, and other
13 factors. Providers shall not be entitled to enrollment in the
14 Medicaid provider network. The agency shall determine
15 instances in which allowing Medicaid beneficiaries to purchase
16 durable medical equipment and other goods is less expensive to
17 the Medicaid program than long-term rental of the equipment or
18 goods. The agency may establish rules to facilitate purchases
19 in lieu of long-term rentals in order to protect against fraud
20 and abuse in the Medicaid program as defined in s. 409.913.
21 The agency may ~~is authorized to~~ seek federal waivers necessary
22 to administer these policies ~~implement this policy.~~

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

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

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1 409.901-409.920.

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

5 (4) The agency may contract with:

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

21 (b) An entity that is providing comprehensive
22 behavioral health care services to certain Medicaid recipients
23 through a capitated, prepaid arrangement pursuant to the
24 federal waiver provided for by s. 409.905(5). Such an entity
25 must be licensed under chapter 624, chapter 636, or chapter
26 641 and must possess the clinical systems and operational
27 competence to manage risk and provide comprehensive behavioral
28 health care to Medicaid recipients. As used in this paragraph,
29 the term "comprehensive behavioral health care services" means
30 covered mental health and substance abuse treatment services
31 that are available to Medicaid recipients. The secretary of

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1 the Department of Children and Family Services shall approve
2 provisions of procurements related to children in the
3 department's care or custody prior to enrolling such children
4 in a prepaid behavioral health plan. Any contract awarded
5 under this paragraph must be competitively procured. In
6 developing the behavioral health care prepaid plan procurement
7 document, the agency shall ensure that the procurement
8 document requires the contractor to develop and implement a
9 plan to ensure compliance with s. 394.4574 related to services
10 provided to residents of licensed assisted living facilities
11 that hold a limited mental health license. Except as provided
12 in subparagraph 8., the agency shall seek federal approval to
13 contract with a single entity meeting these requirements to
14 provide comprehensive behavioral health care services to all
15 Medicaid recipients not enrolled in a managed care plan in an
16 AHCA area. Each entity must offer sufficient choice of
17 providers in its network to ensure recipient access to care
18 and the opportunity to select a provider with whom they are
19 satisfied. The network shall include all public mental health
20 hospitals. To ensure unimpaired access to behavioral health
21 care services by Medicaid recipients, all contracts issued
22 pursuant to this paragraph shall require 80 percent of the
23 capitation paid to the managed care plan, including health
24 maintenance organizations, to be expended for the provision of
25 behavioral health care services. In the event the managed care
26 plan expends less than 80 percent of the capitation paid
27 pursuant to this paragraph for the provision of behavioral
28 health care services, the difference shall be returned to the
29 agency. The agency shall provide the managed care plan with a
30 certification letter indicating the amount of capitation paid
31 during each calendar year for the provision of behavioral

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1 health care services pursuant to this section. The agency may
 2 reimburse for substance abuse treatment services on a
 3 fee-for-service basis until the agency finds that adequate
 4 funds are available for capitated, prepaid arrangements.

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

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

16 3. Except as provided in subparagraph 8., by July 1,
 17 2006, the agency and the Department of Children and Family
 18 Services shall contract with managed care entities in each
 19 AHCA area except area 6 or arrange to provide comprehensive
 20 inpatient and outpatient mental health and substance abuse
 21 services through capitated prepaid arrangements to all
 22 Medicaid recipients who are eligible to participate in such
 23 plans under federal law and regulation. In AHCA areas where
 24 eligible individuals number less than 150,000, the agency
 25 shall contract with a single managed care plan to provide
 26 comprehensive behavioral health services to all recipients who
 27 are not enrolled in a Medicaid health maintenance
 28 organization. The agency may contract with more than one
 29 comprehensive behavioral health provider to provide care to
 30 recipients who are not enrolled in a Medicaid health
 31 maintenance organization in AHCA areas where the eligible

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1 population exceeds 150,000. Contracts for comprehensive
2 behavioral health providers awarded pursuant to this section
3 shall be competitively procured. Both for-profit and
4 not-for-profit corporations shall be eligible to compete.
5 Managed care plans contracting with the agency under
6 subsection (3) shall provide and receive payment for the same
7 comprehensive behavioral health benefits as provided in AHCA
8 rules, including handbooks incorporated by reference.

9 4. By October 1, 2003, the agency and the department
10 shall submit a plan to the Governor, the President of the
11 Senate, and the Speaker of the House of Representatives which
12 provides for the full implementation of capitated prepaid
13 behavioral health care in all areas of the state.

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

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

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

29 5. Children residing in a statewide inpatient
30 psychiatric program, or in a Department of Juvenile Justice or
31 a Department of Children and Family Services residential

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1 program approved as a Medicaid behavioral health overlay
2 services provider shall not be included in a behavioral health
3 care prepaid health plan or any other Medicaid managed care
4 plan pursuant to this paragraph.

5 6. In converting to a prepaid system of delivery, the
6 agency shall in its procurement document require an entity
7 providing only comprehensive behavioral health care services
8 to prevent the displacement of indigent care patients by
9 enrollees in the Medicaid prepaid health plan providing
10 behavioral health care services from facilities receiving
11 state funding to provide indigent behavioral health care, to
12 facilities licensed under chapter 395 which do not receive
13 state funding for indigent behavioral health care, or
14 reimburse the unsubsidized facility for the cost of behavioral
15 health care provided to the displaced indigent care patient.

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

24 8. For fiscal year 2004-2005, all Medicaid eligible
25 children, except children in areas 1 and 6, whose cases are
26 open for child welfare services in the HomeSafeNet system,
27 shall be enrolled in MediPass or in Medicaid fee-for-service
28 and all their behavioral health care services including
29 inpatient, outpatient psychiatric, community mental health,
30 and case management shall be reimbursed on a fee-for-service
31 basis. Beginning July 1, 2005, such children, who are open for

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1 child welfare services in the HomeSafeNet system, shall
 2 receive their behavioral health care services through a
 3 specialty prepaid plan operated by community-based lead
 4 agencies either through a single agency or formal agreements
 5 among several agencies. The specialty prepaid plan must result
 6 in savings to the state comparable to savings achieved in
 7 other Medicaid managed care and prepaid programs. Such plan
 8 must provide mechanisms to maximize state and local revenues.
 9 The specialty prepaid plan shall be developed by the agency
 10 and the Department of Children and Family Services. The agency
 11 is authorized to seek any federal waivers to implement this
 12 initiative.

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

25 (d) A provider service network may be reimbursed on a
 26 fee-for-service or prepaid basis. A provider service network
 27 which is reimbursed by the agency on a prepaid basis shall be
 28 exempt from parts I and III of chapter 641, but must meet
 29 appropriate financial reserve, quality assurance, and patient
 30 rights requirements as established by the agency. The agency
 31 shall award contracts on a competitive bid basis and shall

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1 select bidders based upon price and quality of care. Medicaid
2 recipients assigned to a demonstration project shall be chosen
3 equally from those who would otherwise have been assigned to
4 prepaid plans and MediPass. The agency is authorized to seek
5 federal Medicaid waivers as necessary to implement the
6 provisions of this section. Any contract previously awarded to
7 a provider service network operated by a hospital pursuant to
8 this subsection shall remain in effect for a period of 3 years
9 following the current contract-expiration date, regardless of
10 any contractual provisions to the contrary. A provider service
11 network is a network established or organized and operated by
12 a health care provider, or group of affiliated health care
13 providers, which provides a substantial proportion of the
14 health care items and services under a contract directly
15 through the provider or affiliated group of providers and may
16 make arrangements with physicians or other health care
17 professionals, health care institutions, or any combination of
18 such individuals or institutions to assume all or part of the
19 financial risk on a prospective basis for the provision of
20 basic health services by the physicians, by other health
21 professionals, or through the institutions. The health care
22 providers must have a controlling interest in the governing
23 body of the provider service network organization.

24 (e) An entity that provides only comprehensive
25 behavioral health care services to certain Medicaid recipients
26 through an administrative services organization agreement.
27 Such an entity must possess the clinical systems and
28 operational competence to provide comprehensive health care to
29 Medicaid recipients. As used in this paragraph, the term
30 "comprehensive behavioral health care services" means covered
31 mental health and substance abuse treatment services that are

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1 available to Medicaid recipients. Any contract awarded under
 2 this paragraph must be competitively procured. The agency must
 3 ensure that Medicaid recipients have available the choice of
 4 at least two managed care plans for their behavioral health
 5 care services.

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

15 (g) Children's provider networks that provide care
 16 coordination and care management for Medicaid-eligible
 17 pediatric patients, primary care, authorization of specialty
 18 care, and other urgent and emergency care through organized
 19 providers designed to service Medicaid eligibles under age 18
 20 and pediatric emergency departments' diversion programs. The
 21 networks shall provide after-hour operations, including
 22 evening and weekend hours, to promote, when appropriate, the
 23 use of the children's networks rather than hospital emergency
 24 departments.

25 (h) An entity authorized in s. 430.205 to contract
 26 with the agency and the Department of Elderly Affairs to
 27 provide health care and social services on a prepaid or
 28 fixed-sum basis to elderly recipients. Such prepaid health
 29 care services entities are exempt from the provisions of part
 30 I of chapter 641 for the first 3 years of operation. An entity
 31 recognized under this paragraph that demonstrates to the

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1 satisfaction of the Office of Insurance Regulation that it is
 2 backed by the full faith and credit of one or more counties in
 3 which it operates may be exempted from s. 641.225.

4 (i) A Children's Medical Services Network, as defined
 5 in s. 391.021.

6 (5) By December 1, 2005, the Agency for Health Care
 7 Administration, in partnership with the Department of Elderly
 8 Affairs, shall create an integrated, fixed-payment delivery
 9 system for Medicaid recipients who are 60 years of age or
 10 older. The Agency for Health Care Administration shall
 11 implement the integrated system initially on a pilot basis in
 12 two areas of the state. In one of the areas enrollment shall
 13 be on a voluntary basis. The program must transfer all
 14 Medicaid services for eligible elderly individuals who choose
 15 to participate into an integrated-care management model
 16 designed to serve Medicaid recipients in the community. The
 17 program must combine all funding for Medicaid services
 18 provided to individuals 60 years of age or older into the
 19 integrated system, including funds for Medicaid home and
 20 community-based waiver services; all Medicaid services
 21 authorized in ss. 409.905 and 409.906, excluding funds for
 22 Medicaid nursing home services unless the agency is able to
 23 demonstrate how the integration of the funds will improve
 24 coordinated care for these services in a less costly manner;
 25 and Medicare coinsurance and deductibles for persons dually
 26 eligible for Medicaid and Medicare as prescribed in s.
 27 409.908(13).

28 (a) Individuals who are 60 years of age or older and
 29 enrolled in the the developmental disabilities waiver program,
 30 the family and supported-living waiver program, the project
 31 AIDS care waiver program, the traumatic brain injury and

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1 spinal cord injury waiver program, the consumer-directed care
2 waiver program, and the program of all-inclusive care for the
3 elderly program, and residents of institutional care
4 facilities for the developmentally disabled, must be excluded
5 from the integrated system.

6 (b) The program must use a competitive-procurement
7 process to select entities to operate the integrated system.
8 Entities eligible to submit bids include managed care
9 organizations licensed under chapter 641, including entities
10 eligible to participate in the nursing home diversion program,
11 other qualified providers as defined in s. 430.703(7),
12 community care for the elderly lead agencies, and other
13 state-certified community service networks that meet
14 comparable standards as defined by the agency, in consultation
15 with the Department of Elderly Affairs and the Office of
16 Insurance Regulation, to be financially solvent and able to
17 take on financial risk for managed care. Community service
18 networks that are certified pursuant to the comparable
19 standards defined by the agency are not required to be
20 licensed under chapter 641.

21 (c) The agency must ensure that the
22 capitation-rate-setting methodology for the integrated system
23 is actuarially sound and reflects the intent to provide
24 quality care in the least-restrictive setting. The agency must
25 also require integrated-system providers to develop a
26 credentialing system for service providers and to contract
27 with all Gold Seal nursing homes, where feasible, and exclude,
28 where feasible, chronically poor-performing facilities and
29 providers as defined by the agency. The integrated system must
30 provide that if the recipient resides in a noncontracted
31 residential facility licensed under chapter 400 at the time

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1 the integrated system is initiated, the recipient must be
2 permitted to continue to reside in the noncontracted facility
3 as long as the recipient desires. The integrated system must
4 also provide that, in the absence of a contract between the
5 integrated-system provider and the residential facility
6 licensed under chapter 400, current Medicaid rates must
7 prevail. The agency and the Department of Elderly Affairs must
8 jointly develop procedures to manage the services provided
9 through the integrated system in order to ensure quality and
10 recipient choice.

11 (d) Within 24 months after implementation, the Office
12 of Program Policy Analysis and Government Accountability, in
13 consultation with the Auditor General, shall comprehensively
14 evaluate the pilot project for the integrated, fixed-payment
15 delivery system for Medicaid recipients who are 60 years of
16 age or older. The evaluation must include assessments of cost
17 savings; consumer education, choice, and access to services;
18 coordination of care; and quality of care. The evaluation must
19 describe administrative or legal barriers to the
20 implementation and operation of the pilot program and include
21 recommendations regarding statewide expansion of the pilot
22 program. The office shall submit an evaluation report to the
23 Governor, the President of the Senate, and the Speaker of the
24 House of Representatives no later than June 30, 2008.

25 (e) The agency may seek federal waivers and adopt
26 rules as necessary to administer the integrated system. The
27 agency must receive specific authorization from the
28 Legislature prior to implementing the waiver for the
29 integrated system. ~~By October 1, 2003, the agency and the~~
30 ~~department shall, to the extent feasible, develop a plan for~~
31 ~~implementing new Medicaid procedure codes for emergency and~~

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1 ~~crisis care, supportive residential services, and other~~
2 ~~services designed to maximize the use of Medicaid funds for~~
3 ~~Medicaid eligible recipients. The agency shall include in the~~
4 ~~agreement developed pursuant to subsection (4) a provision~~
5 ~~that ensures that the match requirements for these new~~
6 ~~procedure codes are met by certifying eligible general revenue~~
7 ~~or local funds that are currently expended on these services~~
8 ~~by the department with contracted alcohol, drug abuse, and~~
9 ~~mental health providers. The plan must describe specific~~
10 ~~procedure codes to be implemented, a projection of the number~~
11 ~~of procedures to be delivered during fiscal year 2003-2004,~~
12 ~~and a financial analysis that describes the certified match~~
13 ~~procedures, and accountability mechanisms, projects the~~
14 ~~earnings associated with these procedures, and describes the~~
15 ~~sources of state match. This plan may not be implemented in~~
16 ~~any part until approved by the Legislative Budget Commission.~~
17 ~~If such approval has not occurred by December 31, 2003, the~~
18 ~~plan shall be submitted for consideration by the 2004~~
19 ~~Legislature.~~

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

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

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

31 (c) Makes provisions satisfactory to the agency for

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1 insolvency protection and ensures that neither enrolled
2 Medicaid recipients nor the agency will be liable for the
3 debts of the entity;

4 (d) Submits to the agency, if a private entity, a
5 financial plan that the agency finds to be fiscally sound and
6 that provides for working capital in the form of cash or
7 equivalent liquid assets excluding revenues from Medicaid
8 premium payments equal to at least the first 3 months of
9 operating expenses or \$200,000, whichever is greater;

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

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

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

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

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

24 (b) Assumes the underwriting risk; and

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

28 (8) The agency may contract on a prepaid or fixed-sum
29 basis with an exclusive provider organization to provide
30 health care services to Medicaid recipients provided that the
31 exclusive provider organization meets applicable managed care

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1 plan requirements in this section, ss. 409.9122, 409.9123,
2 409.9128, and 627.6472, and other applicable provisions of
3 law.

4 (9) The Agency for Health Care Administration may
5 provide cost-effective purchasing of chiropractic services on
6 a fee-for-service basis to Medicaid recipients through
7 arrangements with a statewide chiropractic preferred provider
8 organization incorporated in this state as a not-for-profit
9 corporation. The agency shall ensure that the benefit limits
10 and prior authorization requirements in the current Medicaid
11 program shall apply to the services provided by the
12 chiropractic preferred provider organization.

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

21 (a) Fraud;

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

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

30 (d) Any crime in any jurisdiction which directly
31 relates to the provision of health services on a prepaid or

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1 fixed-sum basis.

2 (11) The agency, after notifying the Legislature, may
3 apply for waivers of applicable federal laws and regulations
4 as necessary to implement more appropriate systems of health
5 care for Medicaid recipients and reduce the cost of the
6 Medicaid program to the state and federal governments and
7 shall implement such programs, after legislative approval,
8 within a reasonable period of time after federal approval.

9 These programs must be designed primarily to reduce the need
10 for inpatient care, custodial care and other long-term or
11 institutional care, and other high-cost services.

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

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

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

28 (13) The agency shall develop and provide coordinated
29 systems of care for Medicaid recipients and may contract with
30 public or private entities to develop and administer such
31 systems of care among public and private health care providers

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1 in a given geographic area.

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

5 (b) The agency shall develop a procedure for
6 determining whether health care providers and service vendors
7 can provide the Medicaid program using a business case that
8 demonstrates whether a particular good or service can offset
9 the cost of providing the good or service in an alternative
10 setting or through other means and therefore should receive a
11 higher reimbursement. The business case must include, but need
12 not be limited to:

13 1. A detailed description of the good or service to be
14 provided, a description and analysis of the agency's current
15 performance of the service, and a rationale documenting how
16 providing the service in an alternative setting would be in
17 the best interest of the state, the agency, and its clients.

18 2. A cost-benefit analysis documenting the estimated
19 specific direct and indirect costs, savings, performance
20 improvements, risks, and qualitative and quantitative benefits
21 involved in or resulting from providing the service. The
22 cost-benefit analysis must include a detailed plan and
23 timeline identifying all actions that must be implemented to
24 realize expected benefits. The Secretary of Health Care
25 Administration shall verify that all costs, savings, and
26 benefits are valid and achievable.

27 (c) If the agency determines that the increased
28 reimbursement is cost-effective, the agency shall recommend a
29 change in the reimbursement schedule for that particular good
30 or service. If, within 12 months after implementing any rate
31 change under this procedure, the agency determines that costs

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1 were not offset by the increased reimbursement schedule, the
2 agency may revert to the former reimbursement schedule for the
3 particular good or service.

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

15 (b) The agency shall operate the CARES program through
16 an interagency agreement with the Department of Elderly
17 Affairs. The agency, in consultation with the Department of
18 Elderly Affairs, may contract for any function or activity of
19 the CARES program, including any function or activity required
20 by 42 C.F.R. part 483.20, relating to preadmission screening
21 and resident review.

22 (c) Prior to making payment for nursing facility
23 services for a Medicaid recipient, the agency must verify that
24 the nursing facility preadmission screening program has
25 determined that the individual requires nursing facility care
26 and that the individual cannot be safely served in
27 community-based programs. The nursing facility preadmission
28 screening program shall refer a Medicaid recipient to a
29 community-based program if the individual could be safely
30 served at a lower cost and the recipient chooses to
31 participate in such program. For individuals whose nursing

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1 home stay is initially funded by Medicare and Medicare
2 coverage is being terminated for lack of progress towards
3 rehabilitation, CARES staff shall consult with the person
4 making the determination of progress toward rehabilitation to
5 ensure that the recipient is not being inappropriately
6 disqualified from Medicare coverage. If, in their professional
7 judgment, CARES staff believes that a Medicare beneficiary is
8 still making progress toward rehabilitation, they may assist
9 the Medicare beneficiary with an appeal of the
10 disqualification from Medicare coverage. The use of CARES
11 teams to review Medicare denials for coverage under this
12 section is authorized only if it is determined that such
13 reviews qualify for federal matching funds through Medicaid.
14 The agency shall seek or amend federal waivers as necessary to
15 implement this section.

16 (d) For the purpose of initiating immediate
17 prescreening and diversion assistance for individuals residing
18 in nursing homes and in order to make families aware of
19 alternative long-term care resources so that they may choose a
20 more cost-effective setting for long-term placement, CARES
21 staff shall conduct an assessment and review of a sample of
22 individuals whose nursing home stay is expected to exceed 20
23 days, regardless of the initial funding source for the nursing
24 home placement. CARES staff shall provide counseling and
25 referral services to these individuals regarding choosing
26 appropriate long-term care alternatives. This paragraph does
27 not apply to continuing care facilities licensed under chapter
28 651 or to retirement communities that provide a combination of
29 nursing home, independent living, and other long-term care
30 services.

31 (e) By January 15 of each year, the agency shall

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1 submit a report to the Legislature and the Office of
2 Long-Term-Care Policy describing the operations of the CARES
3 program. The report must describe:

4 1. Rate of diversion to community alternative
5 programs;

6 2. CARES program staffing needs to achieve additional
7 diversions;

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

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

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

17 (f) The Department of Elderly Affairs shall track
18 individuals over time who are assessed under the CARES program
19 and who are diverted from nursing home placement. By January
20 15 of each year, the department shall submit to the
21 Legislature and the Office of Long-Term-Care Policy a
22 longitudinal study of the individuals who are diverted from
23 nursing home placement. The study must include:

24 1. The demographic characteristics of the individuals
25 assessed and diverted from nursing home placement, including,
26 but not limited to, age, race, gender, frailty, caregiver
27 status, living arrangements, and geographic location;

28 2. A summary of community services provided to
29 individuals for 1 year after assessment and diversion;

30 3. A summary of inpatient hospital admissions for
31 individuals who have been diverted; and

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1 4. A summary of the length of time between diversion
2 and subsequent entry into a nursing home or death.

3 (g) By July 1, 2005, the department and the Agency for
4 Health Care Administration shall report to the President of
5 the Senate and the Speaker of the House of Representatives
6 regarding the impact to the state of modifying level-of-care
7 criteria to eliminate the Intermediate II level of care.

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

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

29 1. The practice pattern identification program shall
30 evaluate practitioner prescribing patterns based on national
31 and regional practice guidelines, comparing practitioners to

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1 their peer groups. The agency and its Drug Utilization Review
2 Board shall consult with the Department of Health and a panel
3 of practicing health care professionals consisting of the
4 following: the Speaker of the House of Representatives and the
5 President of the Senate shall each appoint three physicians
6 licensed under chapter 458 or chapter 459; and the Governor
7 shall appoint two pharmacists licensed under chapter 465 and
8 one dentist licensed under chapter 466 who is an oral surgeon.
9 Terms of the panel members shall expire at the discretion of
10 the appointing official. The panel shall begin its work by
11 August 1, 1999, regardless of the number of appointments made
12 by that date. The advisory panel shall be responsible for
13 evaluating treatment guidelines and recommending ways to
14 incorporate their use in the practice pattern identification
15 program. Practitioners who are prescribing inappropriately or
16 inefficiently, as determined by the agency, may have their
17 prescribing of certain drugs subject to prior authorization or
18 may be terminated from all participation in the Medicaid
19 program.

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

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

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

8 5. By April 1, 2006, the agency shall contract with an
 9 entity to design a database of clinical utilization
 10 information or electronic medical records for Medicaid
 11 providers. This system must be web-based and allow providers
 12 to review on a real-time basis the utilization of Medicaid
 13 services, including, but not limited to, physician office
 14 visits, inpatient and outpatient hospitalizations, laboratory
 15 and pathology services, radiological and other imaging
 16 services, dental care, and patterns of dispensing prescription
 17 drugs in order to coordinate care and identify potential fraud
 18 and abuse.

19 ~~6.5.~~ The agency may apply for any federal waivers
 20 needed to administer ~~implement~~ this paragraph.

21 (17) An entity contracting on a prepaid or fixed-sum
 22 basis shall, in addition to meeting any applicable statutory
 23 surplus requirements, also maintain at all times in the form
 24 of cash, investments that mature in less than 180 days
 25 allowable as admitted assets by the Office of Insurance
 26 Regulation, and restricted funds or deposits controlled by the
 27 agency or the Office of Insurance Regulation, a surplus amount
 28 equal to one-and-one-half times the entity's monthly Medicaid
 29 prepaid revenues. As used in this subsection, the term
 30 "surplus" means the entity's total assets minus total
 31 liabilities. If an entity's surplus falls below an amount

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1 equal to one-and-one-half times the entity's monthly Medicaid
 2 prepaid revenues, the agency shall prohibit the entity from
 3 engaging in marketing and preenrollment activities, shall
 4 cease to process new enrollments, and shall not renew the
 5 entity's contract until the required balance is achieved. The
 6 requirements of this subsection do not apply:

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

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

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

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

18 (18)(a) The agency may require an entity contracting
 19 on a prepaid or fixed-sum basis to establish a restricted
 20 insolvency protection account with a federally guaranteed
 21 financial institution licensed to do business in this state.
 22 The entity shall deposit into that account 5 percent of the
 23 capitation payments made by the agency each month until a
 24 maximum total of 2 percent of the total current contract
 25 amount is reached. The restricted insolvency protection
 26 account may be drawn upon with the authorized signatures of
 27 two persons designated by the entity and two representatives
 28 of the agency. If the agency finds that the entity is
 29 insolvent, the agency may draw upon the account solely with
 30 the two authorized signatures of representatives of the
 31 agency, and the funds may be disbursed to meet financial

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1 obligations incurred by the entity under the prepaid contract.
 2 If the contract is terminated, expired, or not continued, the
 3 account balance must be released by the agency to the entity
 4 upon receipt of proof of satisfaction of all outstanding
 5 obligations incurred under this contract.

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

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

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

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

23 (20) When a merger or acquisition of a Medicaid
 24 prepaid contractor has been approved by the Office of
 25 Insurance Regulation pursuant to s. 628.4615, the agency shall
 26 approve the assignment or transfer of the appropriate Medicaid
 27 prepaid contract upon request of the surviving entity of the
 28 merger or acquisition if the contractor and the other entity
 29 have been in good standing with the agency for the most recent
 30 12-month period, unless the agency determines that the
 31 assignment or transfer would be detrimental to the Medicaid

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1 recipients or the Medicaid program. To be in good standing, an
 2 entity must not have failed accreditation or committed any
 3 material violation of the requirements of s. 641.52 and must
 4 meet the Medicaid contract requirements. For purposes of this
 5 section, a merger or acquisition means a change in controlling
 6 interest of an entity, including an asset or stock purchase.

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

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

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

18 1. False or misleading claims that marketing
 19 representatives are employees or representatives of the state
 20 or county, or of anyone other than the entity or the
 21 organization by whom they are reimbursed.

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

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

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

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

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

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

16 (f) Enrollment of Medicaid recipients.

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

29 (23) A health maintenance organization or a person or
30 entity exempt from chapter 641 that is under contract with the
31 agency for the provision of health care services to Medicaid

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1 recipients may not use or distribute marketing materials used
2 to solicit Medicaid recipients, unless such materials have
3 been approved by the agency. The provisions of this subsection
4 do not apply to general advertising and marketing materials
5 used by a health maintenance organization to solicit both
6 non-Medicaid subscribers and Medicaid recipients.

7 (24) Upon approval by the agency, health maintenance
8 organizations and persons or entities exempt from chapter 641
9 that are under contract with the agency for the provision of
10 health care services to Medicaid recipients may be permitted
11 within the capitation rate to provide additional health
12 benefits that the agency has found are of high quality, are
13 practicably available, provide reasonable value to the
14 recipient, and are provided at no additional cost to the
15 state.

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

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

31 (27) The agency shall establish a health care quality

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1 improvement system for those entities contracting with the
 2 agency pursuant to this section, incorporating all the
 3 standards and guidelines developed by the Medicaid Bureau of
 4 the Health Care Financing Administration as a part of the
 5 quality assurance reform initiative. The system shall include,
 6 but need not be limited to, the following:

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

- 9 1. Written quality assurance program descriptions.
- 10 2. Responsibilities of the governing body for
 11 monitoring, evaluating, and making improvements to care.
- 12 3. An active quality assurance committee.
- 13 4. Quality assurance program supervision.
- 14 5. Requiring the program to have adequate resources to
 15 effectively carry out its specified activities.
- 16 6. Provider participation in the quality assurance
 17 program.
- 18 7. Delegation of quality assurance program activities.
- 19 8. Credentialing and recredentialing.
- 20 9. Enrollee rights and responsibilities.
- 21 10. Availability and accessibility to services and
 22 care.
- 23 11. Ambulatory care facilities.
- 24 12. Accessibility and availability of medical records,
 25 as well as proper recordkeeping and process for record review.
- 26 13. Utilization review.
- 27 14. A continuity of care system.
- 28 15. Quality assurance program documentation.
- 29 16. Coordination of quality assurance activity with
 30 other management activity.
- 31 17. Delivering care to pregnant women and infants; to

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1 elderly and disabled recipients, especially those who are at
2 risk of institutional placement; to persons with developmental
3 disabilities; and to adults who have chronic, high-cost
4 medical conditions.

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

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

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

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

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

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

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

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

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1 activities.

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

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

7 6. Methods for implementing focused studies.

8 7. Individual care review.

9 8. Followup activities.

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

27 (29) The agency shall perform enrollments and
28 disenrollments for Medicaid recipients who are eligible for
29 MediPass or managed care plans. Notwithstanding the
30 prohibition contained in paragraph (21)(f), managed care plans
31 may perform preenrollments of Medicaid recipients under the

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1 supervision of the agency or its agents. For the purposes of
2 this section, "preenrollment" means the provision of marketing
3 and educational materials to a Medicaid recipient and
4 assistance in completing the application forms, but shall not
5 include actual enrollment into a managed care plan. An
6 application for enrollment shall not be deemed complete until
7 the agency or its agent verifies that the recipient made an
8 informed, voluntary choice. The agency, in cooperation with
9 the Department of Children and Family Services, may test new
10 marketing initiatives to inform Medicaid recipients about
11 their managed care options at selected sites. The agency shall
12 report to the Legislature on the effectiveness of such
13 initiatives. The agency may contract with a third party to
14 perform managed care plan and MediPass enrollment and
15 disenrollment services for Medicaid recipients and is
16 authorized to adopt rules to implement such services. The
17 agency may adjust the capitation rate only to cover the costs
18 of a third-party enrollment and disenrollment contract, and
19 for agency supervision and management of the managed care plan
20 enrollment and disenrollment contract.

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

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

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

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

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

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

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

13
 14 The analyses and followup activities conducted by the agency
 15 under its enhanced managed care quality assurance oversight
 16 function shall not duplicate the activities of accreditation
 17 reviewers for entities regulated under part III of chapter
 18 641, but may include a review of the finding of such
 19 reviewers.

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

30 (33) The agency shall, by rule, develop a process
 31 whereby a Medicaid managed care plan enrollee who wishes to

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1 enter hospice care may be disenrolled from the managed care
 2 plan within 24 hours after contacting the agency regarding
 3 such request. The agency rule shall include a methodology for
 4 the agency to recoup managed care plan payments on a pro rata
 5 basis if payment has been made for the enrollment month when
 6 disenrollment occurs.

7 (34) The agency and entities that ~~which~~ contract with
 8 the agency to provide health care services to Medicaid
 9 recipients under this section or ss. 409.91211 and ~~s.~~ 409.9122
 10 must comply with the provisions of s. 641.513 in providing
 11 emergency services and care to Medicaid recipients and
 12 MediPass recipients. Where feasible, safe, and cost-effective,
 13 the agency shall encourage hospitals, emergency medical
 14 services providers, and other public and private health care
 15 providers to work together in their local communities to enter
 16 into agreements or arrangements to ensure access to
 17 alternatives to emergency services and care for those Medicaid
 18 recipients who need nonemergent care. The agency shall
 19 coordinate with hospitals, emergency medical services
 20 providers, private health plans, capitated managed care
 21 networks as established in s. 409.91211, and other public and
 22 private health care providers to implement the provisions of
 23 ss. 395.1041(7), 409.91255(3)(g), 627.6405, and 641.31097 to
 24 develop and implement emergency department diversion programs
 25 for Medicaid recipients.

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

31 (a) Healthy Start prenatal or infant screening.

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

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

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

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

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

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

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

25 (37) The agency may seek and implement federal waivers
26 necessary to provide for cost-effective purchasing of home
27 health services, private duty nursing services,
28 transportation, independent laboratory services, and durable
29 medical equipment and supplies through competitive bidding
30 pursuant to s. 287.057. The agency may request appropriate
31 waivers from the federal Health Care Financing Administration

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1 in order to competitively bid such services. The agency may
2 exclude providers not selected through the bidding process
3 from the Medicaid provider network.

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

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

10 1. Medicaid prescribed-drug coverage for brand-name
11 drugs for adult Medicaid recipients is limited to the
12 dispensing of four brand-name drugs per month per recipient.
13 Children are exempt from this restriction. Antiretroviral
14 agents are excluded from this limitation. No requirements for
15 prior authorization or other restrictions on medications used
16 to treat mental illnesses such as schizophrenia, severe
17 depression, or bipolar disorder may be imposed on Medicaid
18 recipients. Medications that will be available without
19 restriction for persons with mental illnesses include atypical
20 antipsychotic medications, conventional antipsychotic
21 medications, selective serotonin reuptake inhibitors, and
22 other medications used for the treatment of serious mental
23 illnesses. The agency shall also limit the amount of a
24 prescribed drug dispensed to no more than a 34-day supply. The
25 agency shall continue to provide unlimited generic drugs,
26 contraceptive drugs and items, and diabetic supplies. Although
27 a drug may be included on the preferred drug formulary, it
28 would not be exempt from the four-brand limit. The agency may
29 authorize exceptions to the brand-name-drug restriction based
30 upon the treatment needs of the patients, only when such
31 exceptions are based on prior consultation provided by the

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1 agency or an agency contractor, but the agency must establish
2 procedures to ensure that:

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

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

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

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

27 3. The agency shall develop and implement a process
28 for managing the drug therapies of Medicaid recipients who are
29 using significant numbers of prescribed drugs each month. The
30 management process may include, but is not limited to,
31 comprehensive, physician-directed medical-record reviews,

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1 claims analyses, and case evaluations to determine the medical
2 necessity and appropriateness of a patient's treatment plan
3 and drug therapies. The agency may contract with a private
4 organization to provide drug-program-management services. The
5 Medicaid drug benefit management program shall include
6 initiatives to manage drug therapies for HIV/AIDS patients,
7 patients using 20 or more unique prescriptions in a 180-day
8 period, and the top 1,000 patients in annual spending. The
9 agency shall enroll any Medicaid recipient in the drug benefit
10 management program if he or she meets the specifications of
11 this provision and is not enrolled in a Medicaid health
12 maintenance organization.

13 4. The agency may limit the size of its pharmacy
14 network based on need, competitive bidding, price
15 negotiations, credentialing, or similar criteria. The agency
16 shall give special consideration to rural areas in determining
17 the size and location of pharmacies included in the Medicaid
18 pharmacy network. A pharmacy credentialing process may include
19 criteria such as a pharmacy's full-service status, location,
20 size, patient educational programs, patient consultation,
21 disease-management services, and other characteristics. The
22 agency may impose a moratorium on Medicaid pharmacy enrollment
23 when it is determined that it has a sufficient number of
24 Medicaid-participating providers. The agency must allow
25 dispensing practitioners to participate as a part of the
26 Medicaid pharmacy network regardless of the practitioner's
27 proximity to any other entity that is dispensing prescription
28 drugs under the Medicaid program. A dispensing practitioner
29 must meet all credentialing requirements applicable to his or
30 her practice, as determined by the agency.

31 5. The agency shall develop and implement a program

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1 that requires Medicaid practitioners who prescribe drugs to
2 use a counterfeit-proof prescription pad for Medicaid
3 prescriptions. The agency shall require the use of
4 standardized counterfeit-proof prescription pads by
5 Medicaid-participating prescribers or prescribers who write
6 prescriptions for Medicaid recipients. The agency may
7 implement the program in targeted geographic areas or
8 statewide.

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

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

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1 Committee will consider a product for inclusion on the
2 preferred drug formulary. However, a pharmaceutical
3 manufacturer is not guaranteed placement on the formulary by
4 simply paying the minimum supplemental rebate. Agency
5 decisions will be made on the clinical efficacy of a drug and
6 recommendations of the Medicaid Pharmaceutical and
7 Therapeutics Committee, as well as the price of competing
8 products minus federal and state rebates. The agency is
9 authorized to contract with an outside agency or contractor to
10 conduct negotiations for supplemental rebates. For the
11 purposes of this section, the term "supplemental rebates"
12 means cash rebates. Effective July 1, 2004, value-added
13 programs as a substitution for supplemental rebates are
14 prohibited. The agency is authorized to seek any federal
15 waivers to implement this initiative.

16 8. The agency shall establish an advisory committee
17 for the purposes of studying the feasibility of using a
18 restricted drug formulary for nursing home residents and other
19 institutionalized adults. The committee shall be comprised of
20 seven members appointed by the Secretary of Health Care
21 Administration. The committee members shall include two
22 physicians licensed under chapter 458 or chapter 459; three
23 pharmacists licensed under chapter 465 and appointed from a
24 list of recommendations provided by the Florida Long-Term Care
25 Pharmacy Alliance; and two pharmacists licensed under chapter
26 465.

27 9. The Agency for Health Care Administration shall
28 expand home delivery of pharmacy products. To assist Medicaid
29 patients in securing their prescriptions and reduce program
30 costs, the agency shall expand its current mail-order-pharmacy
31 diabetes-supply program to include all generic and brand-name

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1 | drugs used by Medicaid patients with diabetes. Medicaid
 2 | recipients in the current program may obtain nondiabetes drugs
 3 | on a voluntary basis. This initiative is limited to the
 4 | geographic area covered by the current contract. The agency
 5 | may seek and implement any federal waivers necessary to
 6 | implement this subparagraph.

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

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

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

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

31 | (II) Implement processes for providing feedback to and

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1 educating prescribers using best practice educational
2 materials and peer-to-peer consultation.

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

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

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

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

17 (VII) Disseminate electronic and published materials.

18 (VIII) Hold statewide and regional conferences.

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

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

31 12.a. The agency shall implement a Medicaid

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1 prescription-drug-management system. The agency may contract
 2 with a vendor that has experience in operating
 3 prescription-drug-management systems in order to implement
 4 this system. Any management system that is implemented in
 5 accordance with this subparagraph must rely on cooperation
 6 between physicians and pharmacists to determine appropriate
 7 practice patterns and clinical guidelines to improve the
 8 prescribing, dispensing, and use of drugs in the Medicaid
 9 program. The agency may seek federal waivers to implement this
 10 program.

11 b. The drug-management system must be designed to
 12 improve the quality of care and prescribing practices based on
 13 best-practice guidelines, improve patient adherence to
 14 medication plans, reduce clinical risk, and lower prescribed
 15 drug costs and the rate of inappropriate spending on Medicaid
 16 prescription drugs. The program must:

17 (I) Provide for the development and adoption of
 18 best-practice guidelines for the prescribing and use of drugs
 19 in the Medicaid program, including translating best-practice
 20 guidelines into practice; reviewing prescriber patterns and
 21 comparing them to indicators that are based on national
 22 standards and practice patterns of clinical peers in their
 23 community, statewide, and nationally; and determine deviations
 24 from best-practice guidelines.

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

28 (III) Assess Medicaid recipients who are outliers in
 29 their use of a single or multiple prescription drugs with
 30 regard to the numbers and types of drugs taken, drug dosages,
 31 combination drug therapies, and other indicators of improper

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1 use of prescription drugs.

2 (IV) Alert prescribers to patients who fail to refill
3 prescriptions in a timely fashion, are prescribed multiple
4 drugs that may be redundant or contraindicated, or may have
5 other potential medication problems.

6 (V) Track spending trends for prescription drugs and
7 deviation from best-practice guidelines.

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

11 (VII) Disseminate electronic and published materials.

12 (VIII) Hold statewide and regional conferences.

13 (IX) Implement disease-management programs in
14 cooperation with physicians and pharmacists, along with a
15 model quality-based medication component for individuals
16 having chronic medical conditions.

17 ~~13.12.~~ The agency is authorized to contract for drug
18 rebate administration, including, but not limited to,
19 calculating rebate amounts, invoicing manufacturers,
20 negotiating disputes with manufacturers, and maintaining a
21 database of rebate collections.

22 ~~14.13.~~ The agency may specify the preferred daily
23 dosing form or strength for the purpose of promoting best
24 practices with regard to the prescribing of certain drugs as
25 specified in the General Appropriations Act and ensuring
26 cost-effective prescribing practices.

27 ~~15.14.~~ The agency may require prior authorization for
28 the off-label use of Medicaid-covered prescribed drugs as
29 specified in the General Appropriations Act. The agency may,
30 but is not required to, preauthorize the use of a product for
31 an indication not in the approved labeling. Prior

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1 authorization may require the prescribing professional to
 2 provide information about the rationale and supporting medical
 3 evidence for the off-label use of a drug.

4 ~~16.15.~~ The agency shall implement a return and reuse
 5 program for drugs dispensed by pharmacies to institutional
 6 recipients, which includes payment of a \$5 restocking fee for
 7 the implementation and operation of the program. The return
 8 and reuse program shall be implemented electronically and in a
 9 manner that promotes efficiency. The program must permit a
 10 pharmacy to exclude drugs from the program if it is not
 11 practical or cost-effective for the drug to be included and
 12 must provide for the return to inventory of drugs that cannot
 13 be credited or returned in a cost-effective manner. The agency
 14 shall determine if the program has reduced the amount of
 15 Medicaid prescription drugs which are destroyed on an annual
 16 basis and if there are additional ways to ensure more
 17 prescription drugs are not destroyed which could safely be
 18 reused. The agency's conclusion and recommendations shall be
 19 reported to the Legislature by December 1, 2005.

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

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

30 (40) Notwithstanding the provisions of chapter 287,
 31 the agency may, at its discretion, renew a contract or

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1 contracts for fiscal intermediary services one or more times
2 for such periods as the agency may decide; however, all such
3 renewals may not combine to exceed a total period longer than
4 the term of the original contract.

5 (41) The agency shall provide for the development of a
6 demonstration project by establishment in Miami-Dade County of
7 a long-term-care facility licensed pursuant to chapter 395 to
8 improve access to health care for a predominantly minority,
9 medically underserved, and medically complex population and to
10 evaluate alternatives to nursing home care and general acute
11 care for such population. Such project is to be located in a
12 health care condominium and colocated with licensed facilities
13 providing a continuum of care. The establishment of this
14 project is not subject to the provisions of s. 408.036 or s.
15 408.039. The agency shall report its findings to the Governor,
16 the President of the Senate, and the Speaker of the House of
17 Representatives by January 1, 2003.

18 (42) The agency shall develop and implement a
19 utilization management program for Medicaid-eligible
20 recipients for the management of occupational, physical,
21 respiratory, and speech therapies. The agency shall establish
22 a utilization program that may require prior authorization in
23 order to ensure medically necessary and cost-effective
24 treatments. The program shall be operated in accordance with a
25 federally approved waiver program or state plan amendment. The
26 agency may seek a federal waiver or state plan amendment to
27 implement this program. The agency may also competitively
28 procure these services from an outside vendor on a regional or
29 statewide basis.

30 (43) The agency may contract on a prepaid or fixed-sum
31 basis with appropriately licensed prepaid dental health plans

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1 to provide dental services.

2 (44) The Agency for Health Care Administration shall
3 ensure that any Medicaid managed care plan as defined in s.
4 409.9122(2)(h), whether paid on a capitated basis or a shared
5 savings basis, is cost-effective. For purposes of this
6 subsection, the term "cost-effective" means that a network's
7 per-member, per-month costs to the state, including, but not
8 limited to, fee-for-service costs, administrative costs, and
9 case-management fees, must be no greater than the state's
10 costs associated with contracts for Medicaid services
11 established under subsection (3), which shall be actuarially
12 adjusted for case mix, model, and service area. The agency
13 shall conduct actuarially sound audits adjusted for case mix
14 and model in order to ensure such cost-effectiveness and shall
15 publish the audit results on its Internet website and submit
16 the audit results annually to the Governor, the President of
17 the Senate, and the Speaker of the House of Representatives no
18 later than December 31 of each year. Contracts established
19 pursuant to this subsection which are not cost-effective may
20 not be renewed.

21 (45) Subject to the availability of funds, the agency
22 shall mandate a recipient's participation in a provider
23 lock-in program, when appropriate, if a recipient is found by
24 the agency to have used Medicaid goods or services at a
25 frequency or amount not medically necessary, limiting the
26 receipt of goods or services to medically necessary providers
27 after the 21-day appeal process has ended, for a period of not
28 less than 1 year. The lock-in programs shall include, but are
29 not limited to, pharmacies, medical doctors, and infusion
30 clinics. The limitation does not apply to emergency services
31 and care provided to the recipient in a hospital emergency

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1 department. The agency shall seek any federal waivers
2 necessary to implement this subsection. The agency shall adopt
3 any rules necessary to comply with or administer this
4 subsection.

5 (46) The agency shall seek a federal waiver for
6 permission to terminate the eligibility of a Medicaid
7 recipient who has been found to have committed fraud, through
8 judicial or administrative determination, two times in a
9 period of 5 years.

10 (47) The agency shall conduct a study of available
11 electronic systems for the purpose of verifying the identity
12 and eligibility of a Medicaid recipient. The agency shall
13 recommend to the Legislature a plan to implement an electronic
14 verification system for Medicaid recipients by January 31,
15 2005.

16 (48) A provider is not entitled to enrollment in the
17 Medicaid provider network. The agency may implement a Medicaid
18 fee-for-service provider network controls, including, but not
19 limited to, competitive procurement and provider
20 credentialing. If a credentialing process is used, the agency
21 may limit its provider network based upon the following
22 considerations: beneficiary access to care, provider
23 availability, provider quality standards and quality assurance
24 processes, cultural competency, demographic characteristics of
25 beneficiaries, practice standards, service wait times,
26 provider turnover, provider licensure and accreditation
27 history, program integrity history, peer review, Medicaid
28 policy and billing compliance records, clinical and medical
29 record audit findings, and such other areas that are
30 considered necessary by the agency to ensure the integrity of
31 the program.

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

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

14 (b) The agency shall reimburse each minority physician
15 network as a fee-for-service provider, including the case
16 management fee for primary care, or as a capitated rate
17 provider for Medicaid services. Any savings shall be shared
18 with the minority physician networks pursuant to the contract.

19 (c) For purposes of this subsection, the term
20 "cost-effective" means that a network's per-member, per-month
21 costs to the state, including, but not limited to,
22 fee-for-service costs, administrative costs, and
23 case-management fees, must be no greater than the state's
24 costs associated with contracts for Medicaid services
25 established under subsection (3), which shall be actuarially
26 adjusted for case mix, model, and service area. The agency
27 shall conduct actuarially sound audits adjusted for case mix
28 and model in order to ensure such cost-effectiveness and shall
29 publish the audit results on its Internet website and submit
30 the audit results annually to the Governor, the President of
31 the Senate, and the Speaker of the House of Representatives no

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1 later than December 31. Contracts established pursuant to this
2 subsection which are not cost-effective may not be renewed.

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

5 (50) To the extent permitted by federal law and as
6 allowed under s. 409.906, the agency shall provide
7 reimbursement for emergency mental health care services for
8 Medicaid recipients in crisis-stabilization facilities
9 licensed under s. 394.875 as long as those services are less
10 expensive than the same services provided in a hospital
11 setting.

12 Section 2. Section 409.91211, Florida Statutes, is
13 created to read:

14 409.91211 Medicaid managed care pilot program.--

15 (1) The agency is authorized to seek experimental,
16 pilot, or demonstration project waivers, pursuant to s. 1115
17 of the Social Security Act, to create a statewide initiative
18 to provide for a more efficient and effective service delivery
19 system that enhances quality of care and client outcomes in
20 the Florida Medicaid program pursuant to this section. Phase
21 one of the demonstration shall be implemented in two
22 geographic areas. One demonstration site shall include only
23 Broward County. A second demonstration site shall initially
24 include Duval County and shall be expanded to include Baker,
25 Clay, and Nassau Counties within 1 year after the Duval County
26 program becomes operational. This waiver authority is
27 contingent upon federal approval to preserve the
28 upper-payment-limit funding mechanism for hospitals, including
29 a guarantee of a reasonable growth factor, a methodology to
30 allow the use of a portion of these funds to serve as a risk
31 pool for demonstration sites, provisions to preserve the

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1 state's ability to use intergovernmental transfers, and
 2 provisions to protect the disproportionate share program
 3 authorized pursuant to this chapter. Upon completion of the
 4 evaluation conducted under section 3 of this act, the agency
 5 may request statewide expansion of the demonstration projects.
 6 Statewide phase-in to additional counties shall be contingent
 7 upon review and approval by the Legislature.

8 (2) The Legislature intends for the capitated managed
 9 care pilot program to:

10 (a) Provide recipients in Medicaid fee-for-service or
 11 the MediPass program a comprehensive and coordinated capitated
 12 managed care system for all health care services specified in
 13 ss. 409.905 and 409.906.

14 (b) Stabilize Medicaid expenditures under the pilot
 15 program compared to Medicaid expenditures in the pilot area
 16 for the 3 years before implementation of the pilot program,
 17 while ensuring:

- 18 1. Consumer education and choice.
- 19 2. Access to medically necessary services.
- 20 3. Coordination of preventative, acute, and long-term
 21 care.

- 22 4. Reductions in unnecessary service utilization.

23 (c) Provide an opportunity to evaluate the feasibility
 24 of statewide implementation of capitated managed care networks
 25 as a replacement for the current Medicaid fee-for-service and
 26 MediPass systems.

27 (3) The agency shall have the following powers,
 28 duties, and responsibilities with respect to the development
 29 of a pilot program:

30 (a) To develop and recommend a system to deliver all
 31 mandatory services specified in s. 409.905 and optional

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1 services specified in s. 409.906, as approved by the Centers
2 for Medicare and Medicaid Services and the Legislature in the
3 waiver pursuant to this section. Services to recipients under
4 plan benefits shall include emergency services provided under
5 s. 409.9128.

6 (b) To recommend Medicaid-eligibility categories, from
7 those specified in ss. 409.903 and 409.904, which shall be
8 included in the pilot program.

9 (c) To determine and recommend how to design the
10 managed care pilot program in order to take maximum advantage
11 of all available state and federal funds, including those
12 obtained through intergovernmental transfers, the
13 upper-payment-level funding systems, and the disproportionate
14 share program.

15 (d) To determine and recommend actuarially sound,
16 risk-adjusted capitation rates for Medicaid recipients in the
17 pilot program which can be separated to cover comprehensive
18 care, enhanced services, and catastrophic care.

19 (e) To determine and recommend policies and guidelines
20 for phasing in financial risk for approved provider service
21 networks over a 3-year period. These shall include an option
22 to pay fee-for-service rates that may include a
23 savings-settlement option for at least 2 years. This model may
24 be converted to a risk-adjusted capitated rate in the third
25 year of operation. Federally qualified health centers may be
26 offered an opportunity to accept or decline a contract to
27 participate in any provider network for prepaid primary care
28 services.

29 (f) To determine and recommend provisions related to
30 stop-loss requirements and the transfer of excess cost to
31 catastrophic coverage that accommodates the risks associated

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1 with the development of the pilot program.

2 (g) To determine and recommend a process to be used by
3 the Social Services Estimating Conference to determine and
4 validate the rate of growth of the per-member costs of
5 providing Medicaid services under the managed care pilot
6 program.

7 (h) To determine and recommend program standards and
8 credentialing requirements for capitated managed care networks
9 to participate in the pilot program, including those related
10 to fiscal solvency, quality of care, and adequacy of access to
11 health care providers. It is the intent of the Legislature
12 that, to the extent possible, any pilot program authorized by
13 the state under this section include any federally qualified
14 health center, federally qualified rural health clinic, county
15 health department, or other federally, state, or locally
16 funded entity that serves the geographic areas within the
17 boundaries of the pilot program that requests to participate.
18 This paragraph does not relieve an entity that qualifies as a
19 capitated managed care network under this section from any
20 other licensure or regulatory requirements contained in state
21 or federal law which would otherwise apply to the entity. The
22 standards and credentialing requirements shall be based upon,
23 but are not limited to:

24 1. Compliance with the accreditation requirements as
25 provided in s. 641.512.

26 2. Compliance with early and periodic screening,
27 diagnosis, and treatment screening requirements under federal
28 law.

29 3. The percentage of voluntary disenrollments.

30 4. Immunization rates.

31 5. Standards of the National Committee for Quality

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1 Assurance and other approved accrediting bodies.

2 6. Recommendations of other authoritative bodies.

3 7. Specific requirements of the Medicaid program, or
4 standards designed to specifically meet the unique needs of
5 Medicaid recipients.

6 8. Compliance with the health quality improvement
7 system as established by the agency, which incorporates
8 standards and guidelines developed by the Centers for Medicare
9 and Medicaid Services as part of the quality assurance reform
10 initiative.

11 9. The network's infrastructure capacity to manage
12 financial transactions, recordkeeping, data collection, and
13 other administrative functions.

14 10. The network's ability to submit any financial,
15 programmatic, or patient-encounter data or other information
16 required by the agency to determine the actual services
17 provided and the cost of administering the plan.

18 (i) To develop and recommend a mechanism for providing
19 information to Medicaid recipients for the purpose of
20 selecting a capitated managed care plan. For each plan
21 available to a recipient, the agency, at a minimum shall
22 ensure that the recipient is provided with:

23 1. A list and description of the benefits provided.

24 2. Information about cost sharing.

25 3. Plan performance data, if available.

26 4. An explanation of benefit limitations.

27 5. Contact information, including identification of
28 providers participating in the network, geographic locations,
29 and transportation limitations.

30 6. Any other information the agency determines would
31 facilitate a recipient's understanding of the plan or

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1 insurance that would best meet his or her needs.

2 (j) To develop and recommend a system to ensure that
3 there is a record of recipient acknowledgment that choice
4 counseling has been provided.

5 (k) To develop and recommend a choice counseling
6 system to ensure that the choice counseling process and
7 related material are designed to provide counseling through
8 face-to-face interaction, by telephone, and in writing and
9 through other forms of relevant media. Materials shall be
10 written at the fourth-grade reading level and available in a
11 language other than English when 5 percent of the county
12 speaks a language other than English. Choice counseling shall
13 also use language lines and other services for impaired
14 recipients, such as TTD/TTY.

15 (l) To develop and recommend a system that prohibits
16 capitated managed care plans, their representatives, and
17 providers employed by or contracted with the capitated managed
18 care plans from recruiting persons eligible for or enrolled in
19 Medicaid, from providing inducements to Medicaid recipients to
20 select a particular capitated managed care plan, and from
21 prejudicing Medicaid recipients against other capitated
22 managed care plans. The system shall require the entity
23 performing choice counseling to determine if the recipient has
24 made a choice of a plan or has opted out because of duress,
25 threats, payment to the recipient, or incentives promised to
26 the recipient by a third party. If the choice counseling
27 entity determines that the decision to choose a plan was
28 unlawfully influenced or a plan violated any of the provisions
29 of s. 409.912(21), the choice counseling entity shall
30 immediately report the violation to the agency's program
31 integrity section for investigation. Verification of choice

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1 counseling by the recipient shall include a stipulation that
2 the recipient acknowledges the provisions of this subsection.

3 (m) To develop and recommend a choice counseling
4 system that promotes health literacy and provides information
5 aimed to reduce minority health disparities through outreach
6 activities for Medicaid recipients.

7 (n) To develop and recommend a system for the agency
8 to contract with entities to perform choice counseling. The
9 agency may establish standards and performance contracts,
10 including standards requiring the contractor to hire choice
11 counselors who are representative of the state's diverse
12 population and to train choice counselors in working with
13 culturally diverse populations.

14 (o) To determine and recommend descriptions of the
15 eligibility assignment processes which will be used to
16 facilitate client choice while ensuring pilot programs of
17 adequate enrollment levels. These processes shall ensure that
18 pilot sites have sufficient levels of enrollment to conduct a
19 valid test of the managed care pilot program within a 2-year
20 timeframe.

21 (p) To develop and recommend a system to monitor the
22 provision of health care services in the pilot program,
23 including utilization and quality of health care services for
24 the purpose of ensuring access to medically necessary
25 services. This system shall include an encounter
26 data-information system that collects and reports utilization
27 information. The system shall include a method for verifying
28 data integrity within the database and within the provider's
29 medical records.

30 (q) To recommend a grievance-resolution process for
31 Medicaid recipients enrolled in a capitated managed care

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1 network under the pilot program modeled after the subscriber
2 assistance panel, as created in s. 408.7056. This process
3 shall include a mechanism for an expedited review of no
4 greater than 24 hours after notification of a grievance if the
5 life of a Medicaid recipient is in imminent and emergent
6 jeopardy.

7 (r) To recommend a grievance-resolution process for
8 health care providers employed by or contracted with a
9 capitated managed care network under the pilot program in
10 order to settle disputes among the provider and the managed
11 care network or the provider and the agency.

12 (s) To develop and recommend criteria to designate
13 health care providers as eligible to participate in the pilot
14 program. The agency and capitated managed care networks must
15 follow national guidelines for selecting health care
16 providers, whenever available. These criteria must include at
17 a minimum those criteria specified in s. 409.907.

18 (t) To develop and recommend health care provider
19 agreements for participation in the pilot program.

20 (u) To require that all health care providers under
21 contract with the pilot program be duly licensed in the state,
22 if such licensure is available, and meet other criteria as may
23 be established by the agency. These criteria shall include at
24 a minimum those criteria specified in s. 409.907.

25 (v) To develop and recommend agreements with other
26 state or local governmental programs or institutions for the
27 coordination of health care to eligible individuals receiving
28 services from such programs or institutions.

29 (w) To develop and recommend a system to oversee the
30 activities of pilot program participants, health care
31 providers, capitated managed care networks, and their

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1 representatives in order to prevent fraud or abuse,
 2 overutilization or duplicative utilization, underutilization
 3 or inappropriate denial of services, and neglect of
 4 participants and to recover overpayments as appropriate. For
 5 the purposes of this paragraph, the terms "abuse" and "fraud"
 6 have the meanings as provided in s. 409.913. The agency must
 7 refer incidents of suspected fraud, abuse, overutilization and
 8 duplicative utilization, and underutilization or inappropriate
 9 denial of services to the appropriate regulatory agency.

10 (x) To develop and provide actuarial and benefit
 11 design analyses that indicate the effect on capitation rates
 12 and benefits offered in the pilot program over a prospective
 13 5-year period based on the following assumptions:

14 1. Growth in capitation rates which is limited to the
 15 estimated growth rate in general revenue.

16 2. Growth in capitation rates which is limited to the
 17 average growth rate over the last 3 years in per-recipient
 18 Medicaid expenditures.

19 3. Growth in capitation rates which is limited to the
 20 growth rate of aggregate Medicaid expenditures between the
 21 2003-2004 fiscal year and the 2004-2005 fiscal year.

22 (y) To develop a mechanism to require capitated
 23 managed care plans to reimburse qualified emergency service
 24 providers, including, but not limited to, ambulance services,
 25 in accordance with ss. 409.908 and 409.9128. The pilot program
 26 must include a provision for continuing fee-for-service
 27 payments for emergency services, including but not limited to,
 28 individuals who access ambulance services or emergency
 29 departments and who are subsequently determined to be eligible
 30 for Medicaid services.

31 (z) To develop a system whereby school districts

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1 participating in the certified school match program pursuant
2 to ss. 409.908(21) and 1011.70 shall be reimbursed by
3 Medicaid, subject to the limitations of s. 1011.70(1), for a
4 Medicaid-eligible child participating in the services as
5 authorized in s. 1011.70, as provided for in s. 409.9071,
6 regardless of whether the child is enrolled in a capitated
7 managed care network. Capitated managed care networks must
8 make a good-faith effort to execute agreements with school
9 districts regarding the coordinated provision of services
10 authorized under s. 1011.70. County health departments
11 delivering school-based services pursuant to ss. 381.0056 and
12 381.0057 must be reimbursed by Medicaid for the federal share
13 for a Medicaid-eligible child who receives Medicaid-covered
14 services in a school setting, regardless of whether the child
15 is enrolled in a capitated managed care network. Capitated
16 managed care networks must make a good-faith effort to execute
17 agreements with county health departments regarding the
18 coordinated provision of services to a Medicaid-eligible
19 child. To ensure continuity of care for Medicaid patients, the
20 agency, the Department of Health, and the Department of
21 Education shall develop procedures for ensuring that a
22 student's capitated managed care network provider receives
23 information relating to services provided in accordance with
24 ss. 381.0056, 381.0057, 409.9071, and 1011.70.

25 (aa) To develop and recommend a mechanism whereby
26 Medicaid recipients who are already enrolled in a managed care
27 plan or the MediPass program in the pilot areas shall be
28 offered the opportunity to change to capitated managed care
29 plans on a staggered basis, as defined by the agency. All
30 Medicaid recipients shall have 30 days in which to make a
31 choice of capitated managed care plans. Those Medicaid

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1 recipients who do not make a choice shall be assigned to a
 2 capitated managed care plan in accordance with paragraph
 3 (4)(a). To facilitate continuity of care for a Medicaid
 4 recipient who is also a recipient of Supplemental Security
 5 Income (SSI), prior to assigning the SSI recipient to a
 6 capitated managed care plan, the agency shall determine
 7 whether the SSI recipient has an ongoing relationship with a
 8 provider or capitated managed care plan, and if so, the agency
 9 shall assign the SSI recipient to that provider or capitated
 10 managed care plan where feasible. Those SSI recipients who do
 11 not have such a provider relationship shall be assigned to a
 12 capitated managed care plan provider in accordance with
 13 paragraph (4)(a).

14 (bb) To develop and recommend a service delivery
 15 alternative for children having chronic medical conditions
 16 which establishes a medical home project to provide primary
 17 care services to this population. The project shall provide
 18 community-based primary care services that are integrated with
 19 other subspecialties to meet the medical, developmental, and
 20 emotional needs for children and their families. This project
 21 shall include an evaluation component to determine impacts on
 22 hospitalizations, length of stays, emergency room visits,
 23 costs, and access to care, including specialty care and
 24 patient, and family satisfaction.

25 (cc) To develop and recommend service delivery
 26 mechanisms within capitated managed care plans to provide
 27 Medicaid services as specified in ss. 409.905 and 409.906 to
 28 persons with developmental disabilities sufficient to meet the
 29 medical, developmental, and emotional needs of these persons.

30 (dd) To develop and recommend service delivery
 31 mechanisms within capitated managed care plans to provide

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1 Medicaid services as specified in ss. 409.905 and 409.906 to
 2 Medicaid-eligible children in foster care. These services must
 3 be coordinated with community-based care providers as
 4 specified in s. 409.1675, where available, and be sufficient
 5 to meet the medical, developmental, and emotional needs of
 6 these children.

7 (4)(a) A Medicaid recipient in the pilot area who is
 8 not currently enrolled in a capitated managed care plan upon
 9 implementation is not eligible for services as specified in
 10 ss. 409.905 and 409.906, for the amount of time that the
 11 recipient does not enroll in a capitated managed care network.
 12 If a Medicaid recipient has not enrolled in a capitated
 13 managed care plan within 30 days after eligibility, the agency
 14 shall assign the Medicaid recipient to a capitated managed
 15 care plan based on the assessed needs of the recipient as
 16 determined by the agency. When making assignments, the agency
 17 shall take into account the following criteria:

18 1. A capitated managed care network has sufficient
 19 network capacity to meet the need of members.

20 2. The capitated managed care network has previously
 21 enrolled the recipient as a member, or one of the capitated
 22 managed care network's primary care providers has previously
 23 provided health care to the recipient.

24 3. The agency has knowledge that the member has
 25 previously expressed a preference for a particular capitated
 26 managed care network as indicated by Medicaid fee-for-service
 27 claims data, but has failed to make a choice.

28 4. The capitated managed care network's primary care
 29 providers are geographically accessible to the recipient's
 30 residence.

31 (b) When more than one capitated managed care network

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1 provider meets the criteria specified in paragraph (3)(h), the
2 agency shall make recipient assignments consecutively by
3 family unit.

4 (c) The agency may not engage in practices that are
5 designed to favor one capitated managed care plan over another
6 or that are designed to influence Medicaid recipients to
7 enroll in a particular capitated managed care network in order
8 to strengthen its particular fiscal viability.

9 (d) After a recipient has made a selection or has been
10 enrolled in a capitated managed care network, the recipient
11 shall have 90 days in which to voluntarily disenroll and
12 select another capitated managed care network. After 90 days,
13 no further changes may be made except for cause. Cause shall
14 include, but not be limited to, poor quality of care, lack of
15 access to necessary specialty services, an unreasonable delay
16 or denial of service, inordinate or inappropriate changes of
17 primary care providers, service access impairments due to
18 significant changes in the geographic location of services, or
19 fraudulent enrollment. The agency may require a recipient to
20 use the capitated managed care network's grievance process as
21 specified in paragraph (3)(g) prior to the agency's
22 determination of cause, except in cases in which immediate
23 risk of permanent damage to the recipient's health is alleged.
24 The grievance process, when used, must be completed in time to
25 permit the recipient to disenroll no later than the first day
26 of the second month after the month the disenrollment request
27 was made. If the capitated managed care network, as a result
28 of the grievance process, approves an enrollee's request to
29 disenroll, the agency is not required to make a determination
30 in the case. The agency must make a determination and take
31 final action on a recipient's request so that disenrollment

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1 occurs no later than the first day of the second month after
2 the month the request was made. If the agency fails to act
3 within the specified timeframe, the recipient's request to
4 disenroll is deemed to be approved as of the date agency
5 action was required. Recipients who disagree with the agency's
6 finding that cause does not exist for disenrollment shall be
7 advised of their right to pursue a Medicaid fair hearing to
8 dispute the agency's finding.

9 (e) The agency shall apply for federal waivers from
10 the Centers for Medicare and Medicaid Services to lock
11 eligible Medicaid recipients into a capitated managed care
12 network for 12 months after an open enrollment period. After
13 12 months of enrollment, a recipient may select another
14 capitated managed care network. However, nothing shall prevent
15 a Medicaid recipient from changing primary care providers
16 within the capitated managed care network during the 12-month
17 period.

18 (f) The agency shall apply for federal waivers from
19 the Centers for Medicare and Medicaid Services to allow
20 recipients to purchase health care coverage through an
21 employer-sponsored health insurance plan instead of through a
22 Medicaid-certified plan. This provision shall be known as the
23 opt-out option.

24 1. A recipient who chooses the Medicaid opt-out option
25 shall have an opportunity for a specified period of time, as
26 authorized under a waiver granted by the Centers for Medicare
27 and Medicaid Services, to select and enroll in a
28 Medicaid-certified plan. If the recipient remains in the
29 employer-sponsored plan after the specified period, the
30 recipient shall remain in the opt-out program for at least 1
31 year or until the recipient no longer has access to

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1 employer-sponsored coverage, until the employer's open
2 enrollment period for a person who opts out in order to
3 participate in employer-sponsored coverage, or until the
4 person is no longer eligible for Medicaid, whichever time
5 period is shorter.

6 2. Notwithstanding any other provision of this
7 section, coverage, cost sharing, and any other component of
8 employer-sponsored health insurance shall be governed by
9 applicable state and federal laws.

10 (5) This section does not authorize the agency to
11 implement any provision of s. 1115 of the Social Security Act
12 experimental, pilot, or demonstration project waiver to reform
13 the state Medicaid program in any part of the state other than
14 the two geographic areas specified in this section unless
15 approved by the Legislature.

16 (6) The agency shall develop and submit for approval
17 applications for waivers of applicable federal laws and
18 regulations as necessary to implement the managed care pilot
19 project as defined in this section. The agency shall post all
20 waiver applications under this section on its Internet website
21 30 days before submitting the applications to the United
22 States Centers for Medicare and Medicaid Services. All waiver
23 applications shall be provided for review and comment to the
24 appropriate committees of the Senate and House of
25 Representatives for at least 10 working days prior to
26 submission. All waivers submitted to and approved by the
27 United States Centers for Medicare and Medicaid Services under
28 this section must be approved by the Legislature. Federally
29 approved waivers must be submitted to the President of the
30 Senate and the Speaker of the House of Representatives for
31 referral to the appropriate legislative committees. The

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1 appropriate committees shall recommend whether to approve the
 2 implementation of any waivers to the Legislature as a whole.
 3 The agency shall submit a plan containing a recommended
 4 timeline for implementation of any waivers and budgetary
 5 projections of the effect of the pilot program under this
 6 section on the total Medicaid budget for the 2006-2007 through
 7 2009-2010 state fiscal years. This implementation plan shall
 8 be submitted to the President of the Senate and the Speaker of
 9 the House of Representatives at the same time any waivers are
 10 submitted for consideration by the Legislature.

11 (7) Upon review and approval of the applications for
 12 waivers of applicable federal laws and regulations to
 13 implement the managed care pilot program by the Legislature,
 14 the agency may initiate adoption of rules pursuant to ss.
 15 120.536(1) and 120.54 to implement and administer the managed
 16 care pilot program as provided in this section.

17 Section 3. The Office of Program Policy Analysis and
 18 Government Accountability, in consultation with the Auditor
 19 General, shall comprehensively evaluate the two managed care
 20 pilot programs created under section 409.91211, Florida
 21 Statutes. The evaluation shall begin with the implementation
 22 of the managed care model in the pilot areas and continue for
 23 24 months after the two pilot programs have enrolled Medicaid
 24 recipients and started providing health care services. The
 25 evaluation must include assessments of cost savings; consumer
 26 education, choice, and access to services; coordination of
 27 care; and quality of care by each eligibility category and
 28 managed care plan in each pilot site. The evaluation must
 29 describe administrative or legal barriers to the
 30 implementation and operation of each pilot program and include
 31 recommendations regarding statewide expansion of the managed

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1 care pilot programs. The office shall submit an evaluation
2 report to the Governor, the President of the Senate, and the
3 Speaker of the House of Representatives no later than June 30,
4 2008.

5 Section 4. Section 409.9062, Florida Statutes, is
6 amended to read:

7 409.9062 Lung transplant services for Medicaid
8 recipients.--Subject to the availability of funds and subject
9 to any limitations or directions provided for in the General
10 Appropriations Act or chapter 216, the Agency for Health Care
11 Administration Medicaid program shall pay for medically
12 necessary lung transplant services for Medicaid recipients.
13 These payments must be used to reimburse approved lung
14 transplant facilities a global fee for providing lung
15 transplant services to Medicaid recipients.

16 Section 5. The sums of \$401,098 from the General
17 Revenue Fund and \$593,058 from the Medical Care Trust Fund are
18 appropriated to the Agency for Health Care Administration for
19 the purpose of implementing section 4 during the 2005-2006
20 fiscal year.

21 Section 6. Paragraphs (a) and (j) of subsection (2) of
22 section 409.9122, Florida Statutes, are amended to read:

23 409.9122 Mandatory Medicaid managed care enrollment;
24 programs and procedures.--

25 (2)(a) The agency shall enroll in a managed care plan
26 or MediPass all Medicaid recipients, except those Medicaid
27 recipients who are: in an institution; enrolled in the
28 Medicaid medically needy program; or eligible for both
29 Medicaid and Medicare. Upon enrollment, individuals will be
30 able to change their managed care option during the 90-day opt
31 out period required by federal Medicaid regulations. The

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1 agency is authorized to seek the necessary Medicaid state plan
2 amendment to implement this policy. However, to the extent
3 permitted by federal law, the agency may enroll in a managed
4 care plan or MediPass a Medicaid recipient who is exempt from
5 mandatory managed care enrollment, provided that:

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

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

12 3. The agency receives any necessary waivers from the
13 federal Centers for Medicare and Medicaid Services ~~Health Care~~
14 ~~Financing Administration~~.

15
16 The agency shall develop rules to establish policies by which
17 exceptions to the mandatory managed care enrollment
18 requirement may be made on a case-by-case basis. The rules
19 shall include the specific criteria to be applied when making
20 a determination as to whether to exempt a recipient from
21 mandatory enrollment in a managed care plan or MediPass.
22 School districts participating in the certified school match
23 program pursuant to ss. 409.908(21) and 1011.70 shall be
24 reimbursed by Medicaid, subject to the limitations of s.
25 1011.70(1), for a Medicaid-eligible child participating in the
26 services as authorized in s. 1011.70, as provided for in s.
27 409.9071, regardless of whether the child is enrolled in
28 MediPass or a managed care plan. Managed care plans shall make
29 a good faith effort to execute agreements with school
30 districts regarding the coordinated provision of services
31 authorized under s. 1011.70. County health departments

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1 delivering school-based services pursuant to ss. 381.0056 and
 2 381.0057 shall be reimbursed by Medicaid for the federal share
 3 for a Medicaid-eligible child who receives Medicaid-covered
 4 services in a school setting, regardless of whether the child
 5 is enrolled in MediPass or a managed care plan. Managed care
 6 plans shall make a good faith effort to execute agreements
 7 with county health departments regarding the coordinated
 8 provision of services to a Medicaid-eligible child. To ensure
 9 continuity of care for Medicaid patients, the agency, the
 10 Department of Health, and the Department of Education shall
 11 develop procedures for ensuring that a student's managed care
 12 plan or MediPass provider receives information relating to
 13 services provided in accordance with ss. 381.0056, 381.0057,
 14 409.9071, and 1011.70.

15 (j) The agency shall apply for a federal waiver from
 16 the Centers for Medicare and Medicaid Services ~~Health Care~~
 17 ~~Financing Administration~~ to lock eligible Medicaid recipients
 18 into a managed care plan or MediPass for 12 months after an
 19 open enrollment period. After 12 months' enrollment, a
 20 recipient may select another managed care plan or MediPass
 21 provider. However, nothing shall prevent a Medicaid recipient
 22 from changing primary care providers within the managed care
 23 plan or MediPass program during the 12-month period.

24 Section 7. Subsection (2) of section 409.913, Florida
 25 Statutes, is amended, and subsection (36) is added to that
 26 section, to read:

27 409.913 Oversight of the integrity of the Medicaid
 28 program.--The agency shall operate a program to oversee the
 29 activities of Florida Medicaid recipients, and providers and
 30 their representatives, to ensure that fraudulent and abusive
 31 behavior and neglect of recipients occur to the minimum extent

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1 possible, and to recover overpayments and impose sanctions as
2 appropriate. Beginning January 1, 2003, and each year
3 thereafter, the agency and the Medicaid Fraud Control Unit of
4 the Department of Legal Affairs shall submit a joint report to
5 the Legislature documenting the effectiveness of the state's
6 efforts to control Medicaid fraud and abuse and to recover
7 Medicaid overpayments during the previous fiscal year. The
8 report must describe the number of cases opened and
9 investigated each year; the sources of the cases opened; the
10 disposition of the cases closed each year; the amount of
11 overpayments alleged in preliminary and final audit letters;
12 the number and amount of fines or penalties imposed; any
13 reductions in overpayment amounts negotiated in settlement
14 agreements or by other means; the amount of final agency
15 determinations of overpayments; the amount deducted from
16 federal claiming as a result of overpayments; the amount of
17 overpayments recovered each year; the amount of cost of
18 investigation recovered each year; the average length of time
19 to collect from the time the case was opened until the
20 overpayment is paid in full; the amount determined as
21 uncollectible and the portion of the uncollectible amount
22 subsequently reclaimed from the Federal Government; the number
23 of providers, by type, that are terminated from participation
24 in the Medicaid program as a result of fraud and abuse; and
25 all costs associated with discovering and prosecuting cases of
26 Medicaid overpayments and making recoveries in such cases. The
27 report must also document actions taken to prevent
28 overpayments and the number of providers prevented from
29 enrolling in or reenrolling in the Medicaid program as a
30 result of documented Medicaid fraud and abuse and must
31 recommend changes necessary to prevent or recover

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1 overpayments.

2 (2) The agency shall conduct, or cause to be conducted
3 by contract or otherwise, reviews, investigations, analyses,
4 audits, or any combination thereof, to determine possible
5 fraud, abuse, overpayment, or recipient neglect in the
6 Medicaid program and shall report the findings of any
7 overpayments in audit reports as appropriate. At least 5
8 percent of all audits shall be conducted on a random basis.

9 (36) The agency shall provide to each Medicaid
10 recipient or his or her representative an explanation of
11 benefits in the form of a letter that is mailed to the most
12 recent address of the recipient on the record with the
13 Department of Children and Family Services. The explanation of
14 benefits must include the patient's name, the name of the
15 health care provider and the address of the location where the
16 service was provided, a description of all services billed to
17 Medicaid in terminology that should be understood by a
18 reasonable person, and information on how to report
19 inappropriate or incorrect billing to the agency or other law
20 enforcement entities for review or investigation.

21 Section 8. The Agency for Health Care Administration
22 shall submit to the Legislature by December 15, 2005, a report
23 on the legal and administrative barriers to enforcing section
24 409.9081, Florida Statutes. The report must describe how many
25 services require copayments, which providers collect
26 copayments, and the total amount of copayments collected from
27 recipients for all services required under section 409.9081,
28 Florida Statutes, by provider type for the 2001-2002 through
29 2004-2005 fiscal years. The agency shall recommend a mechanism
30 to enforce the requirement for Medicaid recipients to make
31 copayments which does not shift the copayment amount to the

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1 provider. The agency shall also identify the federal or state
2 laws or regulations that permit Medicaid recipients to declare
3 impoverishment in order to avoid paying the copayment and
4 extent to which these statements of impoverishment are
5 verified. If claims of impoverishment are not currently
6 verified, the agency shall recommend a system for such
7 verification. The report must also identify any other
8 cost-sharing measures that could be imposed on Medicaid
9 recipients.

10 Section 9. The Agency for Health Care Administration
11 shall submit to the Legislature by January 15, 2006,
12 recommendations to ensure that Medicaid is the payer of last
13 resort as required by section 409.910, Florida Statutes. The
14 report must identify the public and private entities that are
15 liable for primary payment of health care services and
16 recommend methods to improve enforcement of third-party
17 liability responsibility and repayment of benefits to the
18 state Medicaid program. The report must estimate the potential
19 recoveries that may be achieved through third-party liability
20 efforts if administrative and legal barriers are removed. The
21 report must recommend whether modifications to the agency's
22 contingency-fee contract for third-party liability could
23 enhance third-party liability for benefits provided to
24 Medicaid recipients.

25 Section 10. By January 15, 2006, the Office of Program
26 Policy Analysis and Government Accountability shall submit to
27 the Legislature a study of the long-term care community
28 diversion pilot project authorized under sections
29 430.701-430.709, Florida Statutes. The study may be conducted
30 by staff of the Office of Program Policy Analysis and
31 Government Accountability or by a consultant obtained through

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1 a competitive bid pursuant to the provisions of chapter 287,
2 Florida Statutes. The study must use a statistically-valid
3 methodology to assess the percent of persons served in the
4 project over a 2-year period who would have required Medicaid
5 nursing home services without the diversion services, which
6 services are most frequently used, and which services are
7 least frequently used. The study must determine whether the
8 project is cost-effective or is an expansion of the Medicaid
9 program because a preponderance of the project enrollees would
10 not have required Medicaid nursing home services within a
11 2-year period regardless of the availability of the project or
12 that the enrollees could have been safely served through
13 another Medicaid program at a lower cost to the state.

14 Section 11. The Agency for Health Care Administration
15 shall identify how many individuals in the long-term care
16 diversion programs who receive care at home have a
17 patient-responsibility payment associated with their
18 participation in the diversion program. If no system is
19 available to assess this information, the agency shall
20 determine the cost of creating a system to identify and
21 collect these payments and whether the cost of developing a
22 system for this purpose is offset by the amount of
23 patient-responsibility payments which could be collected with
24 the system. The agency shall report this information to the
25 Legislature by December 1, 2005.

26 Section 12. The Office of Program Policy Analysis and
27 Government Accountability shall conduct a study of state
28 programs that allow non-Medicaid eligible persons under a
29 certain income level to buy into the Medicaid program as if it
30 was private insurance. The study shall examine Medicaid buy-in
31 programs in other states to determine if there are any models

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1 that can be implemented in Florida which would provide access
 2 to uninsured Floridians and what effect this program would
 3 have on Medicaid expenditures based on the experience of
 4 similar states. The study must also examine whether the
 5 Medically Needy program could be redesigned to be a Medicaid
 6 buy-in program. The study must be submitted to the Legislature
 7 by January 1, 2006.

8 Section 13. The Office of Program Policy Analysis and
 9 Government Accountability, in consultation with the Office of
 10 Attorney General, Medicaid Fraud Control Unit and the Auditor
 11 General, shall conduct a study to examine issues related to
 12 the amount of state and federal dollars lost due to fraud and
 13 abuse in the Medicaid prescription drug program. The study
 14 shall focus on examining whether pharmaceutical manufacturers
 15 and their affiliates and wholesale pharmaceutical
 16 manufacturers and their affiliates that participate in the
 17 Medicaid program in this state, with respect to rebates for
 18 prescription drugs, are inflating the average wholesale price
 19 that is used in determining how much the state pays for
 20 prescription drugs for Medicaid recipients. The study shall
 21 also focus on examining whether the manufacturers and their
 22 affiliates are committing other deceptive pricing practices
 23 with regard to federal and state rebates for prescription
 24 drugs in the Medicaid program in this state. The study,
 25 including findings and recommendations, shall be submitted to
 26 the Governor, the President of the Senate, the Speaker of the
 27 House of Representatives, the Minority Leader of the Senate,
 28 and the Minority Leader of the House of Representatives by
 29 January 1, 2006.

30 Section 14. The sums of \$7,129,241 in recurring
 31 General Revenue Funds, \$9,076,875 in nonrecurring General

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1 Revenue Funds, \$8,608,242 in recurring funds from the
 2 Administrative Trust Fund, and \$9,076,874 in nonrecurring
 3 funds from the Administrative Trust Fund are appropriated and
 4 11 full time equivalent positions are authorized for the
 5 purpose of implementing this act.

6 Section 15. The amendments made to section 393.0661,
 7 Florida Statutes, by the Conference Committee Report on
 8 Committee Substitute for Committee Substitute for Senate Bill
 9 404 are repealed.

10 Section 16. The amendments made to section 409.907,
 11 Florida Statutes, by the Conference Committee Report on
 12 Committee Substitute for Committee Substitute for Senate Bill
 13 404 are repealed.

14 Section 17. The amendments made to the introductory
 15 provision only of section 409.908, Florida Statutes, by the
 16 Conference Committee Report on Committee Substitute for
 17 Committee Substitute for Senate Bill 404 are repealed.

18 Section 18. Section 409.9082, Florida Statutes, as
 19 created by the Conference Committee Report on Committee
 20 Substitute for Committee Substitute for Senate Bill 404, is
 21 repealed.

22 Section 19. Section 23 of the Conference Committee
 23 Report on Committee Substitute for Committee Substitute for
 24 Senate Bill 404 is repealed.

25 Section 20. Subsection (2) of section 409.9124, F.S.,
 26 as amended by section 18 of the Conference Committee Report on
 27 Committee Substitute for Committee Substitute for Senate Bill
 28 404 is amended, and subsection (6) is added to that section,
 29 to read:

30 409.9124 Managed care reimbursement.--

31 (2) Each year prior to establishing new managed care

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

14 (6) For the 2005-2006 fiscal year only, the agency
 15 shall make an additional adjustment in calculating the
 16 capitation payments to prepaid health plans, excluding prepaid
 17 mental health plans. This adjustment must result in an
 18 increase of 2.8 percent in the average per-member, per-month
 19 rate paid to prepaid health plans, excluding prepaid mental
 20 health plans, which are funded from Specific Appropriations
 21 225 and 226 in the 2005-2006 General Appropriations Act.

22 Section 21. The Senate Select Committee on Medicaid
 23 Reform shall study how provider rates are established and
 24 modified, how provider agreements and administrative
 25 rulemaking effect those rates, the discretion allowed by
 26 federal law for the setting of rates by the state, and the
 27 impact of litigation on provider rates. The committee shall
 28 issue a report containing recommendations by March 1, 2006, to
 29 the Governor, the President of the Senate, and the Speaker of
 30 the House of Representatives.

31 Section 22. This act shall take effect July 1, 2005.

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

2 And the title is amended as follows:

3 Delete everything before the enacting clause

4

5 and insert:

6 A bill to be entitled

7 An act relating to Medicaid; amending s.

8 409.912, F.S.; requiring the Agency for Health

9 Care Administration to contract with a vendor

10 to monitor and evaluate the clinical practice

11 patterns of providers; authorizing the agency

12 to competitively bid for single-source

13 providers for certain services; authorizing the

14 agency to examine whether purchasing certain

15 durable medical equipment is more

16 cost-effective than long-term rental of such

17 equipment; providing that a contract awarded to

18 a provider service network remains in effect

19 for a certain period; defining a provider

20 service network; providing health care

21 providers with a controlling interest in the

22 governing body of the provider service network

23 organization; requiring that the agency, in

24 partnership with the Department of Elderly

25 Affairs, develop an integrated, fixed-payment

26 delivery system for Medicaid recipients age 60

27 and older; requiring the Office of Program

28 Policy Analysis and Government Accountability

29 to conduct an evaluation; deleting an obsolete

30 provision requiring the agency to develop a

31 plan for implementing emergency and crisis

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1 care; requiring the agency to develop a system
2 where health care vendors may provide a
3 business case demonstrating that higher
4 reimbursement for a good or service will be
5 offset by cost savings in other goods or
6 services; requiring the Comprehensive
7 Assessment and Review for Long-Term Care
8 Services (CARES) teams to consult with any
9 person making a determination that a nursing
10 home resident funded by Medicare is not making
11 progress toward rehabilitation and assist in
12 any appeals of the decision; requiring the
13 agency to contract with an entity to design a
14 clinical-utilization information database or
15 electronic medical record for Medicaid
16 providers; requiring the agency to coordinate
17 with other entities to create emergency room
18 diversion programs for Medicaid recipients;
19 allowing dispensing practitioners to
20 participate in Medicaid; requiring that the
21 agency implement a Medicaid
22 prescription-drug-management system; requiring
23 the agency to determine the extent that
24 prescription drugs are returned and reused in
25 institutional settings and whether this program
26 could be expanded; authorizing the agency to
27 pay for emergency mental health services
28 provided through licensed crisis-stabilization
29 facilities; creating s. 409.91211, F.S.;

30 specifying waiver authority for the Agency for
31 Health Care Administration to establish a

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1 Medicaid reform program contingent on federal
2 approval to preserve the upper-payment-limit
3 finding mechanism for hospitals and contingent
4 on protection of the disproportionate share
5 program authorized pursuant to ch. 409, F.S.;
6 providing legislative intent; providing powers,
7 duties, and responsibilities of the agency
8 under the pilot program; requiring that the
9 agency submit any waivers to the Legislature
10 for approval before implementation; allowing
11 the agency to develop rules; requiring that the
12 Office of Program Policy Analysis and
13 Government Accountability, in consultation with
14 the Auditor General, evaluate the pilot program
15 and report to the Governor and the Legislature
16 on whether it should be expanded statewide;
17 amending s. 409.9062, F.S.; requiring the
18 Agency for Health Care Administration to
19 reimburse lung transplant facilities a global
20 fee for services provided to Medicaid
21 recipients; providing an appropriation;
22 amending s. 409.9122, F.S.; revising a
23 reference; amending s. 409.913, F.S.; requiring
24 5 percent of all program integrity audits to be
25 conducted on a random basis; requiring that
26 Medicaid recipients be provided with an
27 explanation of benefits; requiring that the
28 agency report to the Legislature on the legal
29 and administrative barriers to enforcing the
30 copayment requirements of s. 409.9081, F.S.;

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1 ensure that Medicaid is the payer of last
2 resort; requiring the Office of Program Policy
3 Analysis and Government Accountability to
4 conduct a study of the long-term care diversion
5 programs; requiring the agency to determine how
6 many individuals in long-term care diversion
7 programs have a patient payment responsibility
8 that is not being collected and to recommend
9 how to collect such payments; requiring the
10 Office of Program Policy Analysis and
11 Government Accountability to conduct a study of
12 Medicaid buy-in programs to determine if these
13 programs can be created in this state without
14 expanding the overall Medicaid program budget
15 or if the Medically Needy program can be
16 changed into a Medicaid buy-in program;
17 providing an appropriation and authorizing
18 positions to implement this act; requiring the
19 Office of Program Policy Analysis and
20 Government Accountability, in consultation with
21 the Office of Attorney General and the Auditor
22 General, to conduct a study to examine whether
23 state and federal dollars are lost due to fraud
24 and abuse in the Medicaid prescription drug
25 program; providing duties; requiring that a
26 report with findings and recommendations be
27 submitted to the Governor and the Legislature
28 by a specified date; repealing the amendments
29 made to ss. 393.0661, 409.907, and 409.9082,
30 F.S., and the amendments made to the
31 introductory provision of s. 409.908, F.S., by

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1 the Conference Committee Report on CS for CS
2 for SB 404, relating to provider agreements and
3 provider methodologies; repealing s. 23 of the
4 Conference Committee Report on CS for CS for SB
5 404, relating to legislative intent; amending
6 s. 409.9124, F.S., as amended by the Conference
7 Committee Report on CS for CS for SB 404;
8 revising provisions requiring the Agency for
9 Health Care Administration to pay certain rates
10 for managed care reimbursement; requiring that
11 the agency make an additional adjustment in
12 calculating the rates paid to prepaid health
13 plans for the 2005-2006 fiscal year; requiring
14 that the Senate Select Committee on Medicaid
15 Reform study various issues concerning Medicaid
16 provider rates and issue a report to the
17 Governor and the Legislature; providing an
18 effective date.

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