1 A bill to be entitled
2 An act relating to Medicaid; amending s.
3 409.912, F.S.; requiring the Agency for Health
4 Care Administration to contract with a vendor
5 to monitor and evaluate the clinical practice
6 patterns of providers; authorizing the agency
7 to competitively bid for single-source
8 providers for certain services; authorizing the
9 agency to examine whether purchasing certain
10 durable medical equipment is more
11 cost-effective than long-term rental of such
12 equipment; providing that a contract awarded to
13 a provider service network remains in effect
14 for a certain period; defining a provider
15 service network; providing health care
16 providers with a controlling interest in the
17 governing body of the provider service network
18 organization; requiring that the agency, in
19 partnership with the Department of Elderly
20 Affairs, develop an integrated, fixed-payment
21 delivery system for Medicaid recipients age 60
22 and older; requiring the Office of Program
23 Policy Analysis and Government Accountability
24 to conduct an evaluation; deleting an obsolete
25 provision requiring the agency to develop a
26 plan for implementing emergency and crisis
27 care; requiring the agency to develop a system
28 where health care vendors may provide a
29 business case demonstrating that higher
30 reimbursement for a good or service will be
31 offset by cost savings in other goods or

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1 services; requiring the Comprehensive
2 Assessment and Review for Long-Term Care
3 Services (CARES) teams to consult with any
4 person making a determination that a nursing
5 home resident funded by Medicare is not making
6 progress toward rehabilitation and assist in
7 any appeals of the decision; requiring the
8 agency to contract with an entity to design a
9 clinical-utilization information database or
10 electronic medical record for Medicaid
11 providers; requiring the agency to coordinate
12 with other entities to create emergency room
13 diversion programs for Medicaid recipients;
14 allowing dispensing practitioners to
15 participate in Medicaid; requiring that the
16 agency implement a Medicaid
17 prescription-drug-management system; requiring
18 the agency to determine the extent that
19 prescription drugs are returned and reused in
20 institutional settings and whether this program
21 could be expanded; authorizing the agency to
22 pay for emergency mental health services
23 provided through licensed crisis-stabilization
24 facilities; creating s. 409.91211, F.S.;
25 specifying waiver authority for the Agency for
26 Health Care Administration to establish a
27 Medicaid reform program contingent on federal
28 approval to preserve the upper-payment-limit
29 finding mechanism for hospitals and contingent
30 on protection of the disproportionate share
31 program authorized pursuant to ch. 409, F.S.;

1 providing legislative intent; providing powers,
2 duties, and responsibilities of the agency
3 under the pilot program; requiring that the
4 agency submit any waivers to the Legislature
5 for approval before implementation; allowing
6 the agency to develop rules; requiring that the
7 Office of Program Policy Analysis and
8 Government Accountability, in consultation with
9 the Auditor General, evaluate the pilot program
10 and report to the Governor and the Legislature
11 on whether it should be expanded statewide;
12 amending s. 409.9062, F.S.; requiring the
13 Agency for Health Care Administration to
14 reimburse lung transplant facilities a global
15 fee for services provided to Medicaid
16 recipients; providing an appropriation;
17 amending s. 409.9122, F.S.; revising a
18 reference; amending s. 409.913, F.S.; requiring
19 5 percent of all program integrity audits to be
20 conducted on a random basis; requiring that
21 Medicaid recipients be provided with an
22 explanation of benefits; requiring that the
23 agency report to the Legislature on the legal
24 and administrative barriers to enforcing the
25 copayment requirements of s. 409.9081, F.S.;
26 requiring the agency to recommend ways to
27 ensure that Medicaid is the payer of last
28 resort; requiring the Office of Program Policy
29 Analysis and Government Accountability to
30 conduct a study of the long-term care diversion
31 programs; requiring the agency to determine how

1 many individuals in long-term care diversion
2 programs have a patient payment responsibility
3 that is not being collected and to recommend
4 how to collect such payments; requiring the
5 Office of Program Policy Analysis and
6 Government Accountability to conduct a study of
7 Medicaid buy-in programs to determine if these
8 programs can be created in this state without
9 expanding the overall Medicaid program budget
10 or if the Medically Needy program can be
11 changed into a Medicaid buy-in program;
12 providing an appropriation and authorizing
13 positions to implement this act; requiring the
14 Office of Program Policy Analysis and
15 Government Accountability, in consultation with
16 the Office of Attorney General and the Auditor
17 General, to conduct a study to examine whether
18 state and federal dollars are lost due to fraud
19 and abuse in the Medicaid prescription drug
20 program; providing duties; requiring that a
21 report with findings and recommendations be
22 submitted to the Governor and the Legislature
23 by a specified date; repealing the amendments
24 made to ss. 393.0661, 409.907, and 409.9082,
25 F.S., and the amendments made to the
26 introductory provision of s. 409.908, F.S., by
27 the Conference Committee Report on CS for CS
28 for SB 404, relating to provider agreements and
29 provider methodologies; repealing s. 23 of the
30 Conference Committee Report on CS for CS for SB
31 404, relating to legislative intent; amending

1 s. 409.9124, F.S., as amended by the Conference
2 Committee Report on CS for CS for SB 404;
3 revising provisions requiring the Agency for
4 Health Care Administration to pay certain rates
5 for managed care reimbursement; requiring that
6 the agency make an additional adjustment in
7 calculating the rates paid to prepaid health
8 plans for the 2005-2006 fiscal year; requiring
9 that the Senate Select Committee on Medicaid
10 Reform study various issues concerning Medicaid
11 provider rates and issue a report to the
12 Governor and the Legislature; providing an
13 effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Section 409.912, Florida Statutes, is
18 amended to read:
19 409.912 Cost-effective purchasing of health care.--The
20 agency shall purchase goods and services for Medicaid
21 recipients in the most cost-effective manner consistent with
22 the delivery of quality medical care. To ensure that medical
23 services are effectively utilized, the agency may, in any
24 case, require a confirmation or second physician's opinion of
25 the correct diagnosis for purposes of authorizing future
26 services under the Medicaid program. This section does not
27 restrict access to emergency services or poststabilization
28 care services as defined in 42 C.F.R. part 438.114. Such
29 confirmation or second opinion shall be rendered in a manner
30 approved by the agency. The agency shall maximize the use of
31 prepaid per capita and prepaid aggregate fixed-sum basis

1 services when appropriate and other alternative service
2 delivery and reimbursement methodologies, including
3 competitive bidding pursuant to s. 287.057, designed to
4 facilitate the cost-effective purchase of a case-managed
5 continuum of care. The agency shall also require providers to
6 minimize the exposure of recipients to the need for acute
7 inpatient, custodial, and other institutional care and the
8 inappropriate or unnecessary use of high-cost services. The
9 agency shall contract with a vendor to monitor and evaluate
10 the clinical practice patterns of providers in order to
11 identify trends that are outside the normal practice patterns
12 of a provider's professional peers or the national guidelines
13 of a provider's professional association. The vendor must be
14 able to provide information and counseling to a provider whose
15 practice patterns are outside the norms, in consultation with
16 the agency, to improve patient care and reduce inappropriate
17 utilization. The agency may mandate prior authorization, drug
18 therapy management, or disease management participation for
19 certain populations of Medicaid beneficiaries, certain drug
20 classes, or particular drugs to prevent fraud, abuse, overuse,
21 and possible dangerous drug interactions. The Pharmaceutical
22 and Therapeutics Committee shall make recommendations to the
23 agency on drugs for which prior authorization is required. The
24 agency shall inform the Pharmaceutical and Therapeutics
25 Committee of its decisions regarding drugs subject to prior
26 authorization. The agency is authorized to limit the entities
27 it contracts with or enrolls as Medicaid providers by
28 developing a provider network through provider credentialing.
29 The agency may competitively bid single-source-provider
30 contracts if procurement of goods or services results in
31 demonstrated cost savings to the state without limiting access

to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may ~~is authorized to~~ seek federal waivers necessary to administer these policies ~~implement this policy~~.

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

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

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1 (3) The agency may contract with health maintenance
2 organizations certified pursuant to part I of chapter 641 for
3 the provision of services to recipients.
4 (4) The agency may contract with:
5 (a) An entity that provides no prepaid health care
6 services other than Medicaid services under contract with the
7 agency and which is owned and operated by a county, county
8 health department, or county-owned and operated hospital to
9 provide health care services on a prepaid or fixed-sum basis
10 to recipients, which entity may provide such prepaid services
11 either directly or through arrangements with other providers.
12 Such prepaid health care services entities must be licensed
13 under parts I and III by January 1, 1998, and until then are
14 exempt from the provisions of part I of chapter 641. An entity
15 recognized under this paragraph which demonstrates to the
16 satisfaction of the Office of Insurance Regulation of the
17 Financial Services Commission that it is backed by the full
18 faith and credit of the county in which it is located may be
19 exempted from s. 641.225.
20 (b) An entity that is providing comprehensive
21 behavioral health care services to certain Medicaid recipients
22 through a capitated, prepaid arrangement pursuant to the
23 federal waiver provided for by s. 409.905(5). Such an entity
24 must be licensed under chapter 624, chapter 636, or chapter
25 641 and must possess the clinical systems and operational
26 competence to manage risk and provide comprehensive behavioral
27 health care to Medicaid recipients. As used in this paragraph,
28 the term "comprehensive behavioral health care services" means
29 covered mental health and substance abuse treatment services
30 that are available to Medicaid recipients. The secretary of
31 the Department of Children and Family Services shall approve

provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a managed care plan in an AHCA area. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may

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1 reimburse for substance abuse treatment services on a
2 fee-for-service basis until the agency finds that adequate
3 funds are available for capitated, prepaid arrangements.
4 1. By January 1, 2001, the agency shall modify the
5 contracts with the entities providing comprehensive inpatient
6 and outpatient mental health care services to Medicaid
7 recipients in Hillsborough, Highlands, Hardee, Manatee, and
8 Polk Counties, to include substance abuse treatment services.
9 2. By July 1, 2003, the agency and the Department of
10 Children and Family Services shall execute a written agreement
11 that requires collaboration and joint development of all
12 policy, budgets, procurement documents, contracts, and
13 monitoring plans that have an impact on the state and Medicaid
14 community mental health and targeted case management programs.
15 3. Except as provided in subparagraph 8., by July 1,
16 2006, the agency and the Department of Children and Family
17 Services shall contract with managed care entities in each
18 AHCA area except area 6 or arrange to provide comprehensive
19 inpatient and outpatient mental health and substance abuse
20 services through capitated prepaid arrangements to all
21 Medicaid recipients who are eligible to participate in such
22 plans under federal law and regulation. In AHCA areas where
23 eligible individuals number less than 150,000, the agency
24 shall contract with a single managed care plan to provide
25 comprehensive behavioral health services to all recipients who
26 are not enrolled in a Medicaid health maintenance
27 organization. The agency may contract with more than one
28 comprehensive behavioral health provider to provide care to
29 recipients who are not enrolled in a Medicaid health
30 maintenance organization in AHCA areas where the eligible
31 population exceeds 150,000. Contracts for comprehensive

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1 behavioral health providers awarded pursuant to this section
2 shall be competitively procured. Both for-profit and
3 not-for-profit corporations shall be eligible to compete.
4 Managed care plans contracting with the agency under
5 subsection (3) shall provide and receive payment for the same
6 comprehensive behavioral health benefits as provided in AHCA
7 rules, including handbooks incorporated by reference.
8 4. By October 1, 2003, the agency and the department
9 shall submit a plan to the Governor, the President of the
10 Senate, and the Speaker of the House of Representatives which
11 provides for the full implementation of capitated prepaid
12 behavioral health care in all areas of the state.
13 a. Implementation shall begin in 2003 in those AHCA
14 areas of the state where the agency is able to establish
15 sufficient capitation rates.
16 b. If the agency determines that the proposed
17 capitation rate in any area is insufficient to provide
18 appropriate services, the agency may adjust the capitation
19 rate to ensure that care will be available. The agency and the
20 department may use existing general revenue to address any
21 additional required match but may not over-obligate existing
22 funds on an annualized basis.
23 c. Subject to any limitations provided for in the
24 General Appropriations Act, the agency, in compliance with
25 appropriate federal authorization, shall develop policies and
26 procedures that allow for certification of local and state
27 funds.
28 5. Children residing in a statewide inpatient
29 psychiatric program, or in a Department of Juvenile Justice or
30 a Department of Children and Family Services residential
31 program approved as a Medicaid behavioral health overlay

1 services provider shall not be included in a behavioral health
2 care prepaid health plan or any other Medicaid managed care
3 plan pursuant to this paragraph.
4 6. In converting to a prepaid system of delivery, the
5 agency shall in its procurement document require an entity
6 providing only comprehensive behavioral health care services
7 to prevent the displacement of indigent care patients by
8 enrollees in the Medicaid prepaid health plan providing
9 behavioral health care services from facilities receiving
10 state funding to provide indigent behavioral health care, to
11 facilities licensed under chapter 395 which do not receive
12 state funding for indigent behavioral health care, or
13 reimburse the unsubsidized facility for the cost of behavioral
14 health care provided to the displaced indigent care patient.
15 7. Traditional community mental health providers under
16 contract with the Department of Children and Family Services
17 pursuant to part IV of chapter 394, child welfare providers
18 under contract with the Department of Children and Family
19 Services in areas 1 and 6, and inpatient mental health
20 providers licensed pursuant to chapter 395 must be offered an
21 opportunity to accept or decline a contract to participate in
22 any provider network for prepaid behavioral health services.
23 8. For fiscal year 2004-2005, all Medicaid eligible
24 children, except children in areas 1 and 6, whose cases are
25 open for child welfare services in the HomeSafeNet system,
26 shall be enrolled in MediPass or in Medicaid fee-for-service
27 and all their behavioral health care services including
28 inpatient, outpatient psychiatric, community mental health,
29 and case management shall be reimbursed on a fee-for-service
30 basis. Beginning July 1, 2005, such children, who are open for
31 child welfare services in the HomeSafeNet system, shall

1 receive their behavioral health care services through a
2 specialty prepaid plan operated by community-based lead
3 agencies either through a single agency or formal agreements
4 among several agencies. The specialty prepaid plan must result
5 in savings to the state comparable to savings achieved in
6 other Medicaid managed care and prepaid programs. Such plan
7 must provide mechanisms to maximize state and local revenues.
8 The specialty prepaid plan shall be developed by the agency
9 and the Department of Children and Family Services. The agency
10 is authorized to seek any federal waivers to implement this
11 initiative.
12 (c) A federally qualified health center or an entity
13 owned by one or more federally qualified health centers or an
14 entity owned by other migrant and community health centers
15 receiving non-Medicaid financial support from the Federal
16 Government to provide health care services on a prepaid or
17 fixed-sum basis to recipients. Such prepaid health care
18 services entity must be licensed under parts I and III of
19 chapter 641, but shall be prohibited from serving Medicaid
20 recipients on a prepaid basis, until such licensure has been
21 obtained. However, such an entity is exempt from s. 641.225 if
22 the entity meets the requirements specified in subsections
23 (17) and (18).
24 (d) A provider service network may be reimbursed on a
25 fee-for-service or prepaid basis. A provider service network
26 which is reimbursed by the agency on a prepaid basis shall be
27 exempt from parts I and III of chapter 641, but must meet
28 appropriate financial reserve, quality assurance, and patient
29 rights requirements as established by the agency. The agency
30 shall award contracts on a competitive bid basis and shall
31 select bidders based upon price and quality of care. Medicaid

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1 recipients assigned to a demonstration project shall be chosen
2 equally from those who would otherwise have been assigned to
3 prepaid plans and MediPass. The agency is authorized to seek
4 federal Medicaid waivers as necessary to implement the
5 provisions of this section. Any contract previously awarded to
6 a provider service network operated by a hospital pursuant to
7 this subsection shall remain in effect for a period of 3 years
8 following the current contract-expiration date, regardless of
9 any contractual provisions to the contrary. A provider service
10 network is a network established or organized and operated by
11 a health care provider, or group of affiliated health care
12 providers, which provides a substantial proportion of the
13 health care items and services under a contract directly
14 through the provider or affiliated group of providers and may
15 make arrangements with physicians or other health care
16 professionals, health care institutions, or any combination of
17 such individuals or institutions to assume all or part of the
18 financial risk on a prospective basis for the provision of
19 basic health services by the physicians, by other health
20 professionals, or through the institutions. The health care
21 providers must have a controlling interest in the governing
22 body of the provider service network organization.
23 (e) An entity that provides only comprehensive
24 behavioral health care services to certain Medicaid recipients
25 through an administrative services organization agreement.
26 Such an entity must possess the clinical systems and
27 operational competence to provide comprehensive health care to
28 Medicaid recipients. As used in this paragraph, the term
29 "comprehensive behavioral health care services" means covered
30 mental health and substance abuse treatment services that are
31 available to Medicaid recipients. Any contract awarded under

this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services.

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

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

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

1 backed by the full faith and credit of one or more counties in
2 which it operates may be exempted from s. 641.225.
3 (i) A Children's Medical Services Network, as defined
4 in s. 391.021.
5 (5) By December 1, 2005, the Agency for Health Care
6 Administration, in partnership with the Department of Elderly
7 Affairs, shall create an integrated, fixed-payment delivery
8 system for Medicaid recipients who are 60 years of age or
9 older. The Agency for Health Care Administration shall
10 implement the integrated system initially on a pilot basis in
11 two areas of the state. In one of the areas enrollment shall
12 be on a voluntary basis. The program must transfer all
13 Medicaid services for eligible elderly individuals who choose
14 to participate into an integrated-care management model
15 designed to serve Medicaid recipients in the community. The
16 program must combine all funding for Medicaid services
17 provided to individuals 60 years of age or older into the
18 integrated system, including funds for Medicaid home and
19 community-based waiver services; all Medicaid services
20 authorized in ss. 409.905 and 409.906, excluding funds for
21 Medicaid nursing home services unless the agency is able to
22 demonstrate how the integration of the funds will improve
23 coordinated care for these services in a less costly manner;
24 and Medicare coinsurance and deductibles for persons dually
25 eligible for Medicaid and Medicare as prescribed in s.
26 409.908(13).
27 (a) Individuals who are 60 years of age or older and
28 enrolled in the the developmental disabilities waiver program,
29 the family and supported-living waiver program, the project
30 AIDS care waiver program, the traumatic brain injury and
31 spinal cord injury waiver program, the consumer-directed care

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1 waiver program, and the program of all-inclusive care for the
2 elderly program, and residents of institutional care
3 facilities for the developmentally disabled, must be excluded
4 from the integrated system.
5 (b) The program must use a competitive-procurement
6 process to select entities to operate the integrated system.
7 Entities eligible to submit bids include managed care
8 organizations licensed under chapter 641, including entities
9 eligible to participate in the nursing home diversion program,
10 other qualified providers as defined in s. 430.703(7),
11 community care for the elderly lead agencies, and other
12 state-certified community service networks that meet
13 comparable standards as defined by the agency, in consultation
14 with the Department of Elderly Affairs and the Office of
15 Insurance Regulation, to be financially solvent and able to
16 take on financial risk for managed care. Community service
17 networks that are certified pursuant to the comparable
18 standards defined by the agency are not required to be
19 licensed under chapter 641.
20 (c) The agency must ensure that the
21 capitation-rate-setting methodology for the integrated system
22 is actuarially sound and reflects the intent to provide
23 quality care in the least-restrictive setting. The agency must
24 also require integrated-system providers to develop a
25 credentialing system for service providers and to contract
26 with all Gold Seal nursing homes, where feasible, and exclude,
27 where feasible, chronically poor-performing facilities and
28 providers as defined by the agency. The integrated system must
29 provide that if the recipient resides in a noncontracted
30 residential facility licensed under chapter 400 at the time
31 the integrated system is initiated, the recipient must be

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1 permitted to continue to reside in the noncontracted facility
2 as long as the recipient desires. The integrated system must
3 also provide that, in the absence of a contract between the
4 integrated-system provider and the residential facility
5 licensed under chapter 400, current Medicaid rates must
6 prevail. The agency and the Department of Elderly Affairs must
7 jointly develop procedures to manage the services provided
8 through the integrated system in order to ensure quality and
9 recipient choice.
10 (d) Within 24 months after implementation, the Office
11 of Program Policy Analysis and Government Accountability, in
12 consultation with the Auditor General, shall comprehensively
13 evaluate the pilot project for the integrated, fixed-payment
14 delivery system for Medicaid recipients who are 60 years of
15 age or older. The evaluation must include assessments of cost
16 savings; consumer education, choice, and access to services;
17 coordination of care; and quality of care. The evaluation must
18 describe administrative or legal barriers to the
19 implementation and operation of the pilot program and include
20 recommendations regarding statewide expansion of the pilot
21 program. The office shall submit an evaluation report to the
22 Governor, the President of the Senate, and the Speaker of the
23 House of Representatives no later than June 30, 2008.
24 (e) The agency may seek federal waivers and adopt
25 rules as necessary to administer the integrated system. The
26 agency must receive specific authorization from the
27 Legislature prior to implementing the waiver for the
28 integrated system. ~~By October 1, 2003, the agency and the~~
29 ~~department shall, to the extent feasible, develop a plan for~~
30 ~~implementing new Medicaid procedure codes for emergency and~~
31 ~~crisis care, supportive residential services, and other~~

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1 ~~services designed to maximize the use of Medicaid funds for~~
2 ~~Medicaid eligible recipients. The agency shall include in the~~
3 ~~agreement developed pursuant to subsection (4) a provision~~
4 ~~that ensures that the match requirements for these new~~
5 ~~procedure codes are met by certifying eligible general revenue~~
6 ~~or local funds that are currently expended on these services~~
7 ~~by the department with contracted alcohol, drug abuse, and~~
8 ~~mental health providers. The plan must describe specific~~
9 ~~procedure codes to be implemented, a projection of the number~~
10 ~~of procedures to be delivered during fiscal year 2003-2004,~~
11 ~~and a financial analysis that describes the certified match~~
12 ~~procedures, and accountability mechanisms, projects the~~
13 ~~earnings associated with these procedures, and describes the~~
14 ~~sources of state match. This plan may not be implemented in~~
15 ~~any part until approved by the Legislative Budget Commission.~~
16 ~~If such approval has not occurred by December 31, 2003, the~~
17 ~~plan shall be submitted for consideration by the 2004~~
18 ~~Legislature.~~
19 (6) The agency may contract with any public or private
20 entity otherwise authorized by this section on a prepaid or
21 fixed-sum basis for the provision of health care services to
22 recipients. An entity may provide prepaid services to
23 recipients, either directly or through arrangements with other
24 entities, if each entity involved in providing services:
25 (a) Is organized primarily for the purpose of
26 providing health care or other services of the type regularly
27 offered to Medicaid recipients;
28 (b) Ensures that services meet the standards set by
29 the agency for quality, appropriateness, and timeliness;
30 (c) Makes provisions satisfactory to the agency for
31 insolvency protection and ensures that neither enrolled

1 Medicaid recipients nor the agency will be liable for the
2 debts of the entity;
3 (d) Submits to the agency, if a private entity, a
4 financial plan that the agency finds to be fiscally sound and
5 that provides for working capital in the form of cash or
6 equivalent liquid assets excluding revenues from Medicaid
7 premium payments equal to at least the first 3 months of
8 operating expenses or $200,000, whichever is greater;
9 (e) Furnishes evidence satisfactory to the agency of
10 adequate liability insurance coverage or an adequate plan of
11 self-insurance to respond to claims for injuries arising out
12 of the furnishing of health care;
13 (f) Provides, through contract or otherwise, for
14 periodic review of its medical facilities and services, as
15 required by the agency; and
16 (g) Provides organizational, operational, financial,
17 and other information required by the agency.
18 (7) The agency may contract on a prepaid or fixed-sum
19 basis with any health insurer that:
20 (a) Pays for health care services provided to enrolled
21 Medicaid recipients in exchange for a premium payment paid by
22 the agency;
23 (b) Assumes the underwriting risk; and
24 (c) Is organized and licensed under applicable
25 provisions of the Florida Insurance Code and is currently in
26 good standing with the Office of Insurance Regulation.
27 (8) The agency may contract on a prepaid or fixed-sum
28 basis with an exclusive provider organization to provide
29 health care services to Medicaid recipients provided that the
30 exclusive provider organization meets applicable managed care
31 plan requirements in this section, ss. 409.9122, 409.9123,

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1 409.9128, and 627.6472, and other applicable provisions of
2 law.
3 (9) The Agency for Health Care Administration may
4 provide cost-effective purchasing of chiropractic services on
5 a fee-for-service basis to Medicaid recipients through
6 arrangements with a statewide chiropractic preferred provider
7 organization incorporated in this state as a not-for-profit
8 corporation. The agency shall ensure that the benefit limits
9 and prior authorization requirements in the current Medicaid
10 program shall apply to the services provided by the
11 chiropractic preferred provider organization.
12 (10) The agency shall not contract on a prepaid or
13 fixed-sum basis for Medicaid services with an entity which
14 knows or reasonably should know that any officer, director,
15 agent, managing employee, or owner of stock or beneficial
16 interest in excess of 5 percent common or preferred stock, or
17 the entity itself, has been found guilty of, regardless of
18 adjudication, or entered a plea of nolo contendere, or guilty,
19 to:
20 (a) Fraud;
21 (b) Violation of federal or state antitrust statutes,
22 including those proscribing price fixing between competitors
23 and the allocation of customers among competitors;
24 (c) Commission of a felony involving embezzlement,
25 theft, forgery, income tax evasion, bribery, falsification or
26 destruction of records, making false statements, receiving
27 stolen property, making false claims, or obstruction of
28 justice; or
29 (d) Any crime in any jurisdiction which directly
30 relates to the provision of health services on a prepaid or
31 fixed-sum basis.

1 (11) The agency, after notifying the Legislature, may
2 apply for waivers of applicable federal laws and regulations
3 as necessary to implement more appropriate systems of health
4 care for Medicaid recipients and reduce the cost of the
5 Medicaid program to the state and federal governments and
6 shall implement such programs, after legislative approval,
7 within a reasonable period of time after federal approval.
8 These programs must be designed primarily to reduce the need
9 for inpatient care, custodial care and other long-term or
10 institutional care, and other high-cost services.
11 (a) Prior to seeking legislative approval of such a
12 waiver as authorized by this subsection, the agency shall
13 provide notice and an opportunity for public comment. Notice
14 shall be provided to all persons who have made requests of the
15 agency for advance notice and shall be published in the
16 Florida Administrative Weekly not less than 28 days prior to
17 the intended action.
18 (b) Notwithstanding s. 216.292, funds that are
19 appropriated to the Department of Elderly Affairs for the
20 Assisted Living for the Elderly Medicaid waiver and are not
21 expended shall be transferred to the agency to fund
22 Medicaid-reimbursed nursing home care.
23 (12) The agency shall establish a postpayment
24 utilization control program designed to identify recipients
25 who may inappropriately overuse or underuse Medicaid services
26 and shall provide methods to correct such misuse.
27 (13) The agency shall develop and provide coordinated
28 systems of care for Medicaid recipients and may contract with
29 public or private entities to develop and administer such
30 systems of care among public and private health care providers
31 in a given geographic area.

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

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

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

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

<u>(c) If the agency determines that the increased reimbursement is cost-effective, the agency shall recommend a change in the reimbursement schedule for that particular good or service. If, within 12 months after implementing any rate change under this procedure, the agency determines that costs were not offset by the increased reimbursement schedule, the</u>

1 agency may revert to the former reimbursement schedule for the
2 particular good or service.
3 (15)(a) The agency shall operate the Comprehensive
4 Assessment and Review for Long-Term Care Services (CARES)
5 nursing facility preadmission screening program to ensure that
6 Medicaid payment for nursing facility care is made only for
7 individuals whose conditions require such care and to ensure
8 that long-term care services are provided in the setting most
9 appropriate to the needs of the person and in the most
10 economical manner possible. The CARES program shall also
11 ensure that individuals participating in Medicaid home and
12 community-based waiver programs meet criteria for those
13 programs, consistent with approved federal waivers.
14 (b) The agency shall operate the CARES program through
15 an interagency agreement with the Department of Elderly
16 Affairs. The agency, in consultation with the Department of
17 Elderly Affairs, may contract for any function or activity of
18 the CARES program, including any function or activity required
19 by 42 C.F.R. part 483.20, relating to preadmission screening
20 and resident review.
21 (c) Prior to making payment for nursing facility
22 services for a Medicaid recipient, the agency must verify that
23 the nursing facility preadmission screening program has
24 determined that the individual requires nursing facility care
25 and that the individual cannot be safely served in
26 community-based programs. The nursing facility preadmission
27 screening program shall refer a Medicaid recipient to a
28 community-based program if the individual could be safely
29 served at a lower cost and the recipient chooses to
30 participate in such program. For individuals whose nursing
31 home stay is initially funded by Medicare and Medicare

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1 coverage is being terminated for lack of progress towards
2 rehabilitation, CARES staff shall consult with the person
3 making the determination of progress toward rehabilitation to
4 ensure that the recipient is not being inappropriately
5 disqualified from Medicare coverage. If, in their professional
6 judgment, CARES staff believes that a Medicare beneficiary is
7 still making progress toward rehabilitation, they may assist
8 the Medicare beneficiary with an appeal of the
9 disqualification from Medicare coverage. The use of CARES
10 teams to review Medicare denials for coverage under this
11 section is authorized only if it is determined that such
12 reviews qualify for federal matching funds through Medicaid.
13 The agency shall seek or amend federal waivers as necessary to
14 implement this section.
15 (d) For the purpose of initiating immediate
16 prescreening and diversion assistance for individuals residing
17 in nursing homes and in order to make families aware of
18 alternative long-term care resources so that they may choose a
19 more cost-effective setting for long-term placement, CARES
20 staff shall conduct an assessment and review of a sample of
21 individuals whose nursing home stay is expected to exceed 20
22 days, regardless of the initial funding source for the nursing
23 home placement. CARES staff shall provide counseling and
24 referral services to these individuals regarding choosing
25 appropriate long-term care alternatives. This paragraph does
26 not apply to continuing care facilities licensed under chapter
27 651 or to retirement communities that provide a combination of
28 nursing home, independent living, and other long-term care
29 services.
30 (e) By January 15 of each year, the agency shall
31 submit a report to the Legislature and the Office of

1 Long-Term-Care Policy describing the operations of the CARES
2 program. The report must describe:
3 1. Rate of diversion to community alternative
4 programs;
5 2. CARES program staffing needs to achieve additional
6 diversions;
7 3. Reasons the program is unable to place individuals
8 in less restrictive settings when such individuals desired
9 such services and could have been served in such settings;
10 4. Barriers to appropriate placement, including
11 barriers due to policies or operations of other agencies or
12 state-funded programs; and
13 5. Statutory changes necessary to ensure that
14 individuals in need of long-term care services receive care in
15 the least restrictive environment.
16 (f) The Department of Elderly Affairs shall track
17 individuals over time who are assessed under the CARES program
18 and who are diverted from nursing home placement. By January
19 15 of each year, the department shall submit to the
20 Legislature and the Office of Long-Term-Care Policy a
21 longitudinal study of the individuals who are diverted from
22 nursing home placement. The study must include:
23 1. The demographic characteristics of the individuals
24 assessed and diverted from nursing home placement, including,
25 but not limited to, age, race, gender, frailty, caregiver
26 status, living arrangements, and geographic location;
27 2. A summary of community services provided to
28 individuals for 1 year after assessment and diversion;
29 3. A summary of inpatient hospital admissions for
30 individuals who have been diverted; and
31

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

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

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

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

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

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.

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

1 (27) The agency shall establish a health care quality
2 improvement system for those entities contracting with the
3 agency pursuant to this section, incorporating all the
4 standards and guidelines developed by the Medicaid Bureau of
5 the Health Care Financing Administration as a part of the
6 quality assurance reform initiative. The system shall include,
7 but need not be limited to, the following:
8 (a) Guidelines for internal quality assurance
9 programs, including standards for:
10 1. Written quality assurance program descriptions.
11 2. Responsibilities of the governing body for
12 monitoring, evaluating, and making improvements to care.
13 3. An active quality assurance committee.
14 4. Quality assurance program supervision.
15 5. Requiring the program to have adequate resources to
16 effectively carry out its specified activities.
17 6. Provider participation in the quality assurance
18 program.
19 7. Delegation of quality assurance program activities.
20 8. Credentialing and recredentialing.
21 9. Enrollee rights and responsibilities.
22 10. Availability and accessibility to services and
23 care.
24 11. Ambulatory care facilities.
25 12. Accessibility and availability of medical records,
26 as well as proper recordkeeping and process for record review.
27 13. Utilization review.
28 14. A continuity of care system.
29 15. Quality assurance program documentation.
30 16. Coordination of quality assurance activity with
31 other management activity.

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1 17. Delivering care to pregnant women and infants; to
2 elderly and disabled recipients, especially those who are at
3 risk of institutional placement; to persons with developmental
4 disabilities; and to adults who have chronic, high-cost
5 medical conditions.
6 (b) Guidelines which require the entities to conduct
7 quality-of-care studies which:
8 1. Target specific conditions and specific health
9 service delivery issues for focused monitoring and evaluation.
10 2. Use clinical care standards or practice guidelines
11 to objectively evaluate the care the entity delivers or fails
12 to deliver for the targeted clinical conditions and health
13 services delivery issues.
14 3. Use quality indicators derived from the clinical
15 care standards or practice guidelines to screen and monitor
16 care and services delivered.
17 (c) Guidelines for external quality review of each
18 contractor which require: focused studies of patterns of care;
19 individual care review in specific situations; and followup
20 activities on previous pattern-of-care study findings and
21 individual-care-review findings. In designing the external
22 quality review function and determining how it is to operate
23 as part of the state's overall quality improvement system, the
24 agency shall construct its external quality review
25 organization and entity contracts to address each of the
26 following:
27 1. Delineating the role of the external quality review
28 organization.
29 2. Length of the external quality review organization
30 contract with the state.
31

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1 3. Participation of the contracting entities in
2 designing external quality review organization review
3 activities.
4 4. Potential variation in the type of clinical
5 conditions and health services delivery issues to be studied
6 at each plan.
7 5. Determining the number of focused pattern-of-care
8 studies to be conducted for each plan.
9 6. Methods for implementing focused studies.
10 7. Individual care review.
11 8. Followup activities.
12 (28) In order to ensure that children receive health
13 care services for which an entity has already been
14 compensated, an entity contracting with the agency pursuant to
15 this section shall achieve an annual Early and Periodic
16 Screening, Diagnosis, and Treatment (EPSDT) Service screening
17 rate of at least 60 percent for those recipients continuously
18 enrolled for at least 8 months. The agency shall develop a
19 method by which the EPSDT screening rate shall be calculated.
20 For any entity which does not achieve the annual 60 percent
21 rate, the entity must submit a corrective action plan for the
22 agency's approval. If the entity does not meet the standard
23 established in the corrective action plan during the specified
24 timeframe, the agency is authorized to impose appropriate
25 contract sanctions. At least annually, the agency shall
26 publicly release the EPSDT Services screening rates of each
27 entity it has contracted with on a prepaid basis to serve
28 Medicaid recipients.
29 (29) The agency shall perform enrollments and
30 disenrollments for Medicaid recipients who are eligible for
31 MediPass or managed care plans. Notwithstanding the

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1 prohibition contained in paragraph (21)(f), managed care plans
2 may perform preenrollments of Medicaid recipients under the
3 supervision of the agency or its agents. For the purposes of
4 this section, "preenrollment" means the provision of marketing
5 and educational materials to a Medicaid recipient and
6 assistance in completing the application forms, but shall not
7 include actual enrollment into a managed care plan. An
8 application for enrollment shall not be deemed complete until
9 the agency or its agent verifies that the recipient made an
10 informed, voluntary choice. The agency, in cooperation with
11 the Department of Children and Family Services, may test new
12 marketing initiatives to inform Medicaid recipients about
13 their managed care options at selected sites. The agency shall
14 report to the Legislature on the effectiveness of such
15 initiatives. The agency may contract with a third party to
16 perform managed care plan and MediPass enrollment and
17 disenrollment services for Medicaid recipients and is
18 authorized to adopt rules to implement such services. The
19 agency may adjust the capitation rate only to cover the costs
20 of a third-party enrollment and disenrollment contract, and
21 for agency supervision and management of the managed care plan
22 enrollment and disenrollment contract.
23 (30) Any lists of providers made available to Medicaid
24 recipients, MediPass enrollees, or managed care plan enrollees
25 shall be arranged alphabetically showing the provider's name
26 and specialty and, separately, by specialty in alphabetical
27 order.
28 (31) The agency shall establish an enhanced managed
29 care quality assurance oversight function, to include at least
30 the following components:
31

1 (a) At least quarterly analysis and followup,
2 including sanctions as appropriate, of managed care
3 participant utilization of services.
4 (b) At least quarterly analysis and followup,
5 including sanctions as appropriate, of quality findings of the
6 Medicaid peer review organization and other external quality
7 assurance programs.
8 (c) At least quarterly analysis and followup,
9 including sanctions as appropriate, of the fiscal viability of
10 managed care plans.
11 (d) At least quarterly analysis and followup,
12 including sanctions as appropriate, of managed care
13 participant satisfaction and disenrollment surveys.
14 (e) The agency shall conduct regular and ongoing
15 Medicaid recipient satisfaction surveys.
16
17 The analyses and followup activities conducted by the agency
18 under its enhanced managed care quality assurance oversight
19 function shall not duplicate the activities of accreditation
20 reviewers for entities regulated under part III of chapter
21 641, but may include a review of the finding of such
22 reviewers.
23 (32) Each managed care plan that is under contract
24 with the agency to provide health care services to Medicaid
25 recipients shall annually conduct a background check with the
26 Florida Department of Law Enforcement of all persons with
27 ownership interest of 5 percent or more or executive
28 management responsibility for the managed care plan and shall
29 submit to the agency information concerning any such person
30 who has been found guilty of, regardless of adjudication, or
31

has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.03.

(33) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs.

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

(35) All entities providing health care services to Medicaid recipients shall make available, and encourage all

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1 pregnant women and mothers with infants to receive, and
2 provide documentation in the medical records to reflect, the
3 following:
4 (a) Healthy Start prenatal or infant screening.
5 (b) Healthy Start care coordination, when screening or
6 other factors indicate need.
7 (c) Healthy Start enhanced services in accordance with
8 the prenatal or infant screening results.
9 (d) Immunizations in accordance with recommendations
10 of the Advisory Committee on Immunization Practices of the
11 United States Public Health Service and the American Academy
12 of Pediatrics, as appropriate.
13 (e) Counseling and services for family planning to all
14 women and their partners.
15 (f) A scheduled postpartum visit for the purpose of
16 voluntary family planning, to include discussion of all
17 methods of contraception, as appropriate.
18 (g) Referral to the Special Supplemental Nutrition
19 Program for Women, Infants, and Children (WIC).
20 (36) Any entity that provides Medicaid prepaid health
21 plan services shall ensure the appropriate coordination of
22 health care services with an assisted living facility in cases
23 where a Medicaid recipient is both a member of the entity's
24 prepaid health plan and a resident of the assisted living
25 facility. If the entity is at risk for Medicaid targeted case
26 management and behavioral health services, the entity shall
27 inform the assisted living facility of the procedures to
28 follow should an emergent condition arise.
29 (37) The agency may seek and implement federal waivers
30 necessary to provide for cost-effective purchasing of home
31 health services, private duty nursing services,

1 transportation, independent laboratory services, and durable
2 medical equipment and supplies through competitive bidding
3 pursuant to s. 287.057. The agency may request appropriate
4 waivers from the federal Health Care Financing Administration
5 in order to competitively bid such services. The agency may
6 exclude providers not selected through the bidding process
7 from the Medicaid provider network.
8 (38) The agency shall enter into agreements with
9 not-for-profit organizations based in this state for the
10 purpose of providing vision screening.
11 (39)(a) The agency shall implement a Medicaid
12 prescribed-drug spending-control program that includes the
13 following components:
14 1. Medicaid prescribed-drug coverage for brand-name
15 drugs for adult Medicaid recipients is limited to the
16 dispensing of four brand-name drugs per month per recipient.
17 Children are exempt from this restriction. Antiretroviral
18 agents are excluded from this limitation. No requirements for
19 prior authorization or other restrictions on medications used
20 to treat mental illnesses such as schizophrenia, severe
21 depression, or bipolar disorder may be imposed on Medicaid
22 recipients. Medications that will be available without
23 restriction for persons with mental illnesses include atypical
24 antipsychotic medications, conventional antipsychotic
25 medications, selective serotonin reuptake inhibitors, and
26 other medications used for the treatment of serious mental
27 illnesses. The agency shall also limit the amount of a
28 prescribed drug dispensed to no more than a 34-day supply. The
29 agency shall continue to provide unlimited generic drugs,
30 contraceptive drugs and items, and diabetic supplies. Although
31 a drug may be included on the preferred drug formulary, it

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1 would not be exempt from the four-brand limit. The agency may
2 authorize exceptions to the brand-name-drug restriction based
3 upon the treatment needs of the patients, only when such
4 exceptions are based on prior consultation provided by the
5 agency or an agency contractor, but the agency must establish
6 procedures to ensure that:
7 a. There will be a response to a request for prior
8 consultation by telephone or other telecommunication device
9 within 24 hours after receipt of a request for prior
10 consultation;
11 b. A 72-hour supply of the drug prescribed will be
12 provided in an emergency or when the agency does not provide a
13 response within 24 hours as required by sub-subparagraph a.;
14 and
15 c. Except for the exception for nursing home residents
16 and other institutionalized adults and except for drugs on the
17 restricted formulary for which prior authorization may be
18 sought by an institutional or community pharmacy, prior
19 authorization for an exception to the brand-name-drug
20 restriction is sought by the prescriber and not by the
21 pharmacy. When prior authorization is granted for a patient in
22 an institutional setting beyond the brand-name-drug
23 restriction, such approval is authorized for 12 months and
24 monthly prior authorization is not required for that patient.
25 2. Reimbursement to pharmacies for Medicaid prescribed
26 drugs shall be set at the lesser of: the average wholesale
27 price (AWP) minus 15.4 percent, the wholesaler acquisition
28 cost (WAC) plus 5.75 percent, the federal upper limit (FUL),
29 the state maximum allowable cost (SMAC), or the usual and
30 customary (UAC) charge billed by the provider.
31

1 3. The agency shall develop and implement a process
2 for managing the drug therapies of Medicaid recipients who are
3 using significant numbers of prescribed drugs each month. The
4 management process may include, but is not limited to,
5 comprehensive, physician-directed medical-record reviews,
6 claims analyses, and case evaluations to determine the medical
7 necessity and appropriateness of a patient's treatment plan
8 and drug therapies. The agency may contract with a private
9 organization to provide drug-program-management services. The
10 Medicaid drug benefit management program shall include
11 initiatives to manage drug therapies for HIV/AIDS patients,
12 patients using 20 or more unique prescriptions in a 180-day
13 period, and the top 1,000 patients in annual spending. The
14 agency shall enroll any Medicaid recipient in the drug benefit
15 management program if he or she meets the specifications of
16 this provision and is not enrolled in a Medicaid health
17 maintenance organization.
18 4. The agency may limit the size of its pharmacy
19 network based on need, competitive bidding, price
20 negotiations, credentialing, or similar criteria. The agency
21 shall give special consideration to rural areas in determining
22 the size and location of pharmacies included in the Medicaid
23 pharmacy network. A pharmacy credentialing process may include
24 criteria such as a pharmacy's full-service status, location,
25 size, patient educational programs, patient consultation,
26 disease-management services, and other characteristics. The
27 agency may impose a moratorium on Medicaid pharmacy enrollment
28 when it is determined that it has a sufficient number of
29 Medicaid-participating providers. <u>The agency must allow</u>
30 <u>dispensing practitioners to participate as a part of the</u>
31 <u>Medicaid pharmacy network regardless of the practitioner's</u>

proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

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

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

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the

1 supplemental rebates the agency may negotiate. The agency may
2 determine that specific products, brand-name or generic, are
3 competitive at lower rebate percentages. Agreement to pay the
4 minimum supplemental rebate percentage will guarantee a
5 manufacturer that the Medicaid Pharmaceutical and Therapeutics
6 Committee will consider a product for inclusion on the
7 preferred drug formulary. However, a pharmaceutical
8 manufacturer is not guaranteed placement on the formulary by
9 simply paying the minimum supplemental rebate. Agency
10 decisions will be made on the clinical efficacy of a drug and
11 recommendations of the Medicaid Pharmaceutical and
12 Therapeutics Committee, as well as the price of competing
13 products minus federal and state rebates. The agency is
14 authorized to contract with an outside agency or contractor to
15 conduct negotiations for supplemental rebates. For the
16 purposes of this section, the term "supplemental rebates"
17 means cash rebates. Effective July 1, 2004, value-added
18 programs as a substitution for supplemental rebates are
19 prohibited. The agency is authorized to seek any federal
20 waivers to implement this initiative.
21 8. The agency shall establish an advisory committee
22 for the purposes of studying the feasibility of using a
23 restricted drug formulary for nursing home residents and other
24 institutionalized adults. The committee shall be comprised of
25 seven members appointed by the Secretary of Health Care
26 Administration. The committee members shall include two
27 physicians licensed under chapter 458 or chapter 459; three
28 pharmacists licensed under chapter 465 and appointed from a
29 list of recommendations provided by the Florida Long-Term Care
30 Pharmacy Alliance; and two pharmacists licensed under chapter
31 465.

1 9. The Agency for Health Care Administration shall
2 expand home delivery of pharmacy products. To assist Medicaid
3 patients in securing their prescriptions and reduce program
4 costs, the agency shall expand its current mail-order-pharmacy
5 diabetes-supply program to include all generic and brand-name
6 drugs used by Medicaid patients with diabetes. Medicaid
7 recipients in the current program may obtain nondiabetes drugs
8 on a voluntary basis. This initiative is limited to the
9 geographic area covered by the current contract. The agency
10 may seek and implement any federal waivers necessary to
11 implement this subparagraph.
12 10. The agency shall limit to one dose per month any
13 drug prescribed to treat erectile dysfunction.
14 11.a. The agency shall implement a Medicaid behavioral
15 drug management system. The agency may contract with a vendor
16 that has experience in operating behavioral drug management
17 systems to implement this program. The agency is authorized to
18 seek federal waivers to implement this program.
19 b. The agency, in conjunction with the Department of
20 Children and Family Services, may implement the Medicaid
21 behavioral drug management system that is designed to improve
22 the quality of care and behavioral health prescribing
23 practices based on best practice guidelines, improve patient
24 adherence to medication plans, reduce clinical risk, and lower
25 prescribed drug costs and the rate of inappropriate spending
26 on Medicaid behavioral drugs. The program shall include the
27 following elements:
28 (I) Provide for the development and adoption of best
29 practice guidelines for behavioral health-related drugs such
30 as antipsychotics, antidepressants, and medications for
31 treating bipolar disorders and other behavioral conditions;

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1 translate them into practice; review behavioral health
2 prescribers and compare their prescribing patterns to a number
3 of indicators that are based on national standards; and
4 determine deviations from best practice guidelines.
5 (II) Implement processes for providing feedback to and
6 educating prescribers using best practice educational
7 materials and peer-to-peer consultation.
8 (III) Assess Medicaid beneficiaries who are outliers
9 in their use of behavioral health drugs with regard to the
10 numbers and types of drugs taken, drug dosages, combination
11 drug therapies, and other indicators of improper use of
12 behavioral health drugs.
13 (IV) Alert prescribers to patients who fail to refill
14 prescriptions in a timely fashion, are prescribed multiple
15 same-class behavioral health drugs, and may have other
16 potential medication problems.
17 (V) Track spending trends for behavioral health drugs
18 and deviation from best practice guidelines.
19 (VI) Use educational and technological approaches to
20 promote best practices, educate consumers, and train
21 prescribers in the use of practice guidelines.
22 (VII) Disseminate electronic and published materials.
23 (VIII) Hold statewide and regional conferences.
24 (IX) Implement a disease management program with a
25 model quality-based medication component for severely mentally
26 ill individuals and emotionally disturbed children who are
27 high users of care.
28 c. If the agency is unable to negotiate a contract
29 with one or more manufacturers to finance and guarantee
30 savings associated with a behavioral drug management program
31 by September 1, 2004, the four-brand drug limit and preferred

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1 drug list prior-authorization requirements shall apply to
2 mental health-related drugs, notwithstanding any provision in
3 subparagraph 1. The agency is authorized to seek federal
4 waivers to implement this policy.
5 12.a. The agency shall implement a Medicaid
6 prescription-drug-management system. The agency may contract
7 with a vendor that has experience in operating
8 prescription-drug-management systems in order to implement
9 this system. Any management system that is implemented in
10 accordance with this subparagraph must rely on cooperation
11 between physicians and pharmacists to determine appropriate
12 practice patterns and clinical guidelines to improve the
13 prescribing, dispensing, and use of drugs in the Medicaid
14 program. The agency may seek federal waivers to implement this
15 program.
16 b. The drug-management system must be designed to
17 improve the quality of care and prescribing practices based on
18 best-practice guidelines, improve patient adherence to
19 medication plans, reduce clinical risk, and lower prescribed
20 drug costs and the rate of inappropriate spending on Medicaid
21 prescription drugs. The program must:
22 (I) Provide for the development and adoption of
23 best-practice guidelines for the prescribing and use of drugs
24 in the Medicaid program, including translating best-practice
25 guidelines into practice; reviewing prescriber patterns and
26 comparing them to indicators that are based on national
27 standards and practice patterns of clinical peers in their
28 community, statewide, and nationally; and determine deviations
29 from best-practice guidelines.
30
31

1 (II) Implement processes for providing feedback to and
2 educating prescribers using best-practice educational
3 materials and peer-to-peer consultation.
4 (III) Assess Medicaid recipients who are outliers in
5 their use of a single or multiple prescription drugs with
6 regard to the numbers and types of drugs taken, drug dosages,
7 combination drug therapies, and other indicators of improper
8 use of prescription drugs.
9 (IV) Alert prescribers to patients who fail to refill
10 prescriptions in a timely fashion, are prescribed multiple
11 drugs that may be redundant or contraindicated, or may have
12 other potential medication problems.
13 (V) Track spending trends for prescription drugs and
14 deviation from best-practice guidelines.
15 (VI) Use educational and technological approaches to
16 promote best practices, educate consumers, and train
17 prescribers in the use of practice guidelines.
18 (VII) Disseminate electronic and published materials.
19 (VIII) Hold statewide and regional conferences.
20 (IX) Implement disease-management programs in
21 cooperation with physicians and pharmacists, along with a
22 model quality-based medication component for individuals
23 having chronic medical conditions.
24 13.~~12.~~ The agency is authorized to contract for drug
25 rebate administration, including, but not limited to,
26 calculating rebate amounts, invoicing manufacturers,
27 negotiating disputes with manufacturers, and maintaining a
28 database of rebate collections.
29 14.~~13.~~ The agency may specify the preferred daily
30 dosing form or strength for the purpose of promoting best
31 practices with regard to the prescribing of certain drugs as

1 specified in the General Appropriations Act and ensuring
2 cost-effective prescribing practices.
3 15.~~14.~~ The agency may require prior authorization for
4 the off-label use of Medicaid-covered prescribed drugs as
5 specified in the General Appropriations Act. The agency may,
6 but is not required to, preauthorize the use of a product for
7 an indication not in the approved labeling. Prior
8 authorization may require the prescribing professional to
9 provide information about the rationale and supporting medical
10 evidence for the off-label use of a drug.
11 16.~~15.~~ The agency shall implement a return and reuse
12 program for drugs dispensed by pharmacies to institutional
13 recipients, which includes payment of a $5 restocking fee for
14 the implementation and operation of the program. The return
15 and reuse program shall be implemented electronically and in a
16 manner that promotes efficiency. The program must permit a
17 pharmacy to exclude drugs from the program if it is not
18 practical or cost-effective for the drug to be included and
19 must provide for the return to inventory of drugs that cannot
20 be credited or returned in a cost-effective manner. The agency
21 shall determine if the program has reduced the amount of
22 Medicaid prescription drugs which are destroyed on an annual
23 basis and if there are additional ways to ensure more
24 prescription drugs are not destroyed which could safely be
25 reused. The agency's conclusion and recommendations shall be
26 reported to the Legislature by December 1, 2005.
27 (b) The agency shall implement this subsection to the
28 extent that funds are appropriated to administer the Medicaid
29 prescribed-drug spending-control program. The agency may
30 contract all or any part of this program to private
31 organizations.

1 (c) The agency shall submit quarterly reports to the
2 Governor, the President of the Senate, and the Speaker of the
3 House of Representatives which must include, but need not be
4 limited to, the progress made in implementing this subsection
5 and its effect on Medicaid prescribed-drug expenditures.
6 (40) Notwithstanding the provisions of chapter 287,
7 the agency may, at its discretion, renew a contract or
8 contracts for fiscal intermediary services one or more times
9 for such periods as the agency may decide; however, all such
10 renewals may not combine to exceed a total period longer than
11 the term of the original contract.
12 (41) The agency shall provide for the development of a
13 demonstration project by establishment in Miami-Dade County of
14 a long-term-care facility licensed pursuant to chapter 395 to
15 improve access to health care for a predominantly minority,
16 medically underserved, and medically complex population and to
17 evaluate alternatives to nursing home care and general acute
18 care for such population. Such project is to be located in a
19 health care condominium and colocated with licensed facilities
20 providing a continuum of care. The establishment of this
21 project is not subject to the provisions of s. 408.036 or s.
22 408.039. The agency shall report its findings to the Governor,
23 the President of the Senate, and the Speaker of the House of
24 Representatives by January 1, 2003.
25 (42) The agency shall develop and implement a
26 utilization management program for Medicaid-eligible
27 recipients for the management of occupational, physical,
28 respiratory, and speech therapies. The agency shall establish
29 a utilization program that may require prior authorization in
30 order to ensure medically necessary and cost-effective
31 treatments. The program shall be operated in accordance with a

1 federally approved waiver program or state plan amendment. The
2 agency may seek a federal waiver or state plan amendment to
3 implement this program. The agency may also competitively
4 procure these services from an outside vendor on a regional or
5 statewide basis.
6 (43) The agency may contract on a prepaid or fixed-sum
7 basis with appropriately licensed prepaid dental health plans
8 to provide dental services.
9 (44) The Agency for Health Care Administration shall
10 ensure that any Medicaid managed care plan as defined in s.
11 409.9122(2)(h), whether paid on a capitated basis or a shared
12 savings basis, is cost-effective. For purposes of this
13 subsection, the term "cost-effective" means that a network's
14 per-member, per-month costs to the state, including, but not
15 limited to, fee-for-service costs, administrative costs, and
16 case-management fees, must be no greater than the state's
17 costs associated with contracts for Medicaid services
18 established under subsection (3), which shall be actuarially
19 adjusted for case mix, model, and service area. The agency
20 shall conduct actuarially sound audits adjusted for case mix
21 and model in order to ensure such cost-effectiveness and shall
22 publish the audit results on its Internet website and submit
23 the audit results annually to the Governor, the President of
24 the Senate, and the Speaker of the House of Representatives no
25 later than December 31 of each year. Contracts established
26 pursuant to this subsection which are not cost-effective may
27 not be renewed.
28 (45) Subject to the availability of funds, the agency
29 shall mandate a recipient's participation in a provider
30 lock-in program, when appropriate, if a recipient is found by
31 the agency to have used Medicaid goods or services at a

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1 frequency or amount not medically necessary, limiting the
2 receipt of goods or services to medically necessary providers
3 after the 21-day appeal process has ended, for a period of not
4 less than 1 year. The lock-in programs shall include, but are
5 not limited to, pharmacies, medical doctors, and infusion
6 clinics. The limitation does not apply to emergency services
7 and care provided to the recipient in a hospital emergency
8 department. The agency shall seek any federal waivers
9 necessary to implement this subsection. The agency shall adopt
10 any rules necessary to comply with or administer this
11 subsection.
12 (46) The agency shall seek a federal waiver for
13 permission to terminate the eligibility of a Medicaid
14 recipient who has been found to have committed fraud, through
15 judicial or administrative determination, two times in a
16 period of 5 years.
17 (47) The agency shall conduct a study of available
18 electronic systems for the purpose of verifying the identity
19 and eligibility of a Medicaid recipient. The agency shall
20 recommend to the Legislature a plan to implement an electronic
21 verification system for Medicaid recipients by January 31,
22 2005.
23 (48) A provider is not entitled to enrollment in the
24 Medicaid provider network. The agency may implement a Medicaid
25 fee-for-service provider network controls, including, but not
26 limited to, competitive procurement and provider
27 credentialing. If a credentialing process is used, the agency
28 may limit its provider network based upon the following
29 considerations: beneficiary access to care, provider
30 availability, provider quality standards and quality assurance
31 processes, cultural competency, demographic characteristics of

1 beneficiaries, practice standards, service wait times,
2 provider turnover, provider licensure and accreditation
3 history, program integrity history, peer review, Medicaid
4 policy and billing compliance records, clinical and medical
5 record audit findings, and such other areas that are
6 considered necessary by the agency to ensure the integrity of
7 the program.
8 (49) The agency shall contract with established
9 minority physician networks that provide services to
10 historically underserved minority patients. The networks must
11 provide cost-effective Medicaid services, comply with the
12 requirements to be a MediPass provider, and provide their
13 primary care physicians with access to data and other
14 management tools necessary to assist them in ensuring the
15 appropriate use of services, including inpatient hospital
16 services and pharmaceuticals.
17 (a) The agency shall provide for the development and
18 expansion of minority physician networks in each service area
19 to provide services to Medicaid recipients who are eligible to
20 participate under federal law and rules.
21 (b) The agency shall reimburse each minority physician
22 network as a fee-for-service provider, including the case
23 management fee for primary care, or as a capitated rate
24 provider for Medicaid services. Any savings shall be shared
25 with the minority physician networks pursuant to the contract.
26 (c) For purposes of this subsection, the term
27 "cost-effective" means that a network's per-member, per-month
28 costs to the state, including, but not limited to,
29 fee-for-service costs, administrative costs, and
30 case-management fees, must be no greater than the state's
31 costs associated with contracts for Medicaid services

1 established under subsection (3), which shall be actuarially
2 adjusted for case mix, model, and service area. The agency
3 shall conduct actuarially sound audits adjusted for case mix
4 and model in order to ensure such cost-effectiveness and shall
5 publish the audit results on its Internet website and submit
6 the audit results annually to the Governor, the President of
7 the Senate, and the Speaker of the House of Representatives no
8 later than December 31. Contracts established pursuant to this
9 subsection which are not cost-effective may not be renewed.
10 (d) The agency may apply for any federal waivers
11 needed to implement this subsection.
12 (50) To the extent permitted by federal law and as
13 allowed under s. 409.906, the agency shall provide
14 reimbursement for emergency mental health care services for
15 Medicaid recipients in crisis-stabilization facilities
16 licensed under s. 394.875 as long as those services are less
17 expensive than the same services provided in a hospital
18 setting.
19 Section 2. Section 409.91211, Florida Statutes, is
20 created to read:
21 409.91211 Medicaid managed care pilot program.--
22 (1) The agency is authorized to seek experimental,
23 pilot, or demonstration project waivers, pursuant to s. 1115
24 of the Social Security Act, to create a statewide initiative
25 to provide for a more efficient and effective service delivery
26 system that enhances quality of care and client outcomes in
27 the Florida Medicaid program pursuant to this section. Phase
28 one of the demonstration shall be implemented in two
29 geographic areas. One demonstration site shall include only
30 Broward County. A second demonstration site shall initially
31 include Duval County and shall be expanded to include Baker,

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1 Clay, and Nassau Counties within 1 year after the Duval County
2 program becomes operational. This waiver authority is
3 contingent upon federal approval to preserve the
4 upper-payment-limit funding mechanism for hospitals, including
5 a guarantee of a reasonable growth factor, a methodology to
6 allow the use of a portion of these funds to serve as a risk
7 pool for demonstration sites, provisions to preserve the
8 state's ability to use intergovernmental transfers, and
9 provisions to protect the disproportionate share program
10 authorized pursuant to this chapter. Upon completion of the
11 evaluation conducted under section 3 of this act, the agency
12 may request statewide expansion of the demonstration projects.
13 Statewide phase-in to additional counties shall be contingent
14 upon review and approval by the Legislature.
15 (2) The Legislature intends for the capitated managed
16 care pilot program to:
17 (a) Provide recipients in Medicaid fee-for-service or
18 the MediPass program a comprehensive and coordinated capitated
19 managed care system for all health care services specified in
20 ss. 409.905 and 409.906.
21 (b) Stabilize Medicaid expenditures under the pilot
22 program compared to Medicaid expenditures in the pilot area
23 for the 3 years before implementation of the pilot program,
24 while ensuring:
25 1. Consumer education and choice.
26 2. Access to medically necessary services.
27 3. Coordination of preventative, acute, and long-term
28 care.
29 4. Reductions in unnecessary service utilization.
30 (c) Provide an opportunity to evaluate the feasibility
31 of statewide implementation of capitated managed care networks

1 as a replacement for the current Medicaid fee-for-service and
2 MediPass systems.
3 (3) The agency shall have the following powers,
4 duties, and responsibilities with respect to the development
5 of a pilot program:
6 (a) To develop and recommend a system to deliver all
7 mandatory services specified in s. 409.905 and optional
8 services specified in s. 409.906, as approved by the Centers
9 for Medicare and Medicaid Services and the Legislature in the
10 waiver pursuant to this section. Services to recipients under
11 plan benefits shall include emergency services provided under
12 s. 409.9128.
13 (b) To recommend Medicaid-eligibility categories, from
14 those specified in ss. 409.903 and 409.904, which shall be
15 included in the pilot program.
16 (c) To determine and recommend how to design the
17 managed care pilot program in order to take maximum advantage
18 of all available state and federal funds, including those
19 obtained through intergovernmental transfers, the
20 upper-payment-level funding systems, and the disproportionate
21 share program.
22 (d) To determine and recommend actuarially sound,
23 risk-adjusted capitation rates for Medicaid recipients in the
24 pilot program which can be separated to cover comprehensive
25 care, enhanced services, and catastrophic care.
26 (e) To determine and recommend policies and guidelines
27 for phasing in financial risk for approved provider service
28 networks over a 3-year period. These shall include an option
29 to pay fee-for-service rates that may include a
30 savings-settlement option for at least 2 years. This model may
31 be converted to a risk-adjusted capitated rate in the third

1 year of operation. Federally qualified health centers may be
2 offered an opportunity to accept or decline a contract to
3 participate in any provider network for prepaid primary care
4 services.
5 (f) To determine and recommend provisions related to
6 stop-loss requirements and the transfer of excess cost to
7 catastrophic coverage that accommodates the risks associated
8 with the development of the pilot program.
9 (g) To determine and recommend a process to be used by
10 the Social Services Estimating Conference to determine and
11 validate the rate of growth of the per-member costs of
12 providing Medicaid services under the managed care pilot
13 program.
14 (h) To determine and recommend program standards and
15 credentialing requirements for capitated managed care networks
16 to participate in the pilot program, including those related
17 to fiscal solvency, quality of care, and adequacy of access to
18 health care providers. It is the intent of the Legislature
19 that, to the extent possible, any pilot program authorized by
20 the state under this section include any federally qualified
21 health center, federally qualified rural health clinic, county
22 health department, or other federally, state, or locally
23 funded entity that serves the geographic areas within the
24 boundaries of the pilot program that requests to participate.
25 This paragraph does not relieve an entity that qualifies as a
26 capitated managed care network under this section from any
27 other licensure or regulatory requirements contained in state
28 or federal law which would otherwise apply to the entity. The
29 standards and credentialing requirements shall be based upon,
30 but are not limited to:
31

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

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

3. The percentage of voluntary disenrollments.

4. Immunization rates.

5. Standards of the National Committee for Quality Assurance and other approved accrediting bodies.

6. Recommendations of other authoritative bodies.

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

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

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

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

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

1. A list and description of the benefits provided.

1 2. Information about cost sharing.
2 3. Plan performance data, if available.
3 4. An explanation of benefit limitations.
4 5. Contact information, including identification of
5 providers participating in the network, geographic locations,
6 and transportation limitations.
7 6. Any other information the agency determines would
8 facilitate a recipient's understanding of the plan or
9 insurance that would best meet his or her needs.
10 (j) To develop and recommend a system to ensure that
11 there is a record of recipient acknowledgment that choice
12 counseling has been provided.
13 (k) To develop and recommend a choice counseling
14 system to ensure that the choice counseling process and
15 related material are designed to provide counseling through
16 face-to-face interaction, by telephone, and in writing and
17 through other forms of relevant media. Materials shall be
18 written at the fourth-grade reading level and available in a
19 language other than English when 5 percent of the county
20 speaks a language other than English. Choice counseling shall
21 also use language lines and other services for impaired
22 recipients, such as TTD/TTY.
23 (l) To develop and recommend a system that prohibits
24 capitated managed care plans, their representatives, and
25 providers employed by or contracted with the capitated managed
26 care plans from recruiting persons eligible for or enrolled in
27 Medicaid, from providing inducements to Medicaid recipients to
28 select a particular capitated managed care plan, and from
29 prejudicing Medicaid recipients against other capitated
30 managed care plans. The system shall require the entity
31 performing choice counseling to determine if the recipient has

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1 made a choice of a plan or has opted out because of duress,
2 threats, payment to the recipient, or incentives promised to
3 the recipient by a third party. If the choice counseling
4 entity determines that the decision to choose a plan was
5 unlawfully influenced or a plan violated any of the provisions
6 of s. 409.912(21), the choice counseling entity shall
7 immediately report the violation to the agency's program
8 integrity section for investigation. Verification of choice
9 counseling by the recipient shall include a stipulation that
10 the recipient acknowledges the provisions of this subsection.
11 (m) To develop and recommend a choice counseling
12 system that promotes health literacy and provides information
13 aimed to reduce minority health disparities through outreach
14 activities for Medicaid recipients.
15 (n) To develop and recommend a system for the agency
16 to contract with entities to perform choice counseling. The
17 agency may establish standards and performance contracts,
18 including standards requiring the contractor to hire choice
19 counselors who are representative of the state's diverse
20 population and to train choice counselors in working with
21 culturally diverse populations.
22 (o) To determine and recommend descriptions of the
23 eligibility assignment processes which will be used to
24 facilitate client choice while ensuring pilot programs of
25 adequate enrollment levels. These processes shall ensure that
26 pilot sites have sufficient levels of enrollment to conduct a
27 valid test of the managed care pilot program within a 2-year
28 timeframe.
29 (p) To develop and recommend a system to monitor the
30 provision of health care services in the pilot program,
31 including utilization and quality of health care services for

1 the purpose of ensuring access to medically necessary
2 services. This system shall include an encounter
3 data-information system that collects and reports utilization
4 information. The system shall include a method for verifying
5 data integrity within the database and within the provider's
6 medical records.
7 (q) To recommend a grievance-resolution process for
8 Medicaid recipients enrolled in a capitated managed care
9 network under the pilot program modeled after the subscriber
10 assistance panel, as created in s. 408.7056. This process
11 shall include a mechanism for an expedited review of no
12 greater than 24 hours after notification of a grievance if the
13 life of a Medicaid recipient is in imminent and emergent
14 jeopardy.
15 (r) To recommend a grievance-resolution process for
16 health care providers employed by or contracted with a
17 capitated managed care network under the pilot program in
18 order to settle disputes among the provider and the managed
19 care network or the provider and the agency.
20 (s) To develop and recommend criteria to designate
21 health care providers as eligible to participate in the pilot
22 program. The agency and capitated managed care networks must
23 follow national guidelines for selecting health care
24 providers, whenever available. These criteria must include at
25 a minimum those criteria specified in s. 409.907.
26 (t) To develop and recommend health care provider
27 agreements for participation in the pilot program.
28 (u) To require that all health care providers under
29 contract with the pilot program be duly licensed in the state,
30 if such licensure is available, and meet other criteria as may
31

1 be established by the agency. These criteria shall include at
2 a minimum those criteria specified in s. 409.907.
3 (v) To develop and recommend agreements with other
4 state or local governmental programs or institutions for the
5 coordination of health care to eligible individuals receiving
6 services from such programs or institutions.
7 (w) To develop and recommend a system to oversee the
8 activities of pilot program participants, health care
9 providers, capitated managed care networks, and their
10 representatives in order to prevent fraud or abuse,
11 overutilization or duplicative utilization, underutilization
12 or inappropriate denial of services, and neglect of
13 participants and to recover overpayments as appropriate. For
14 the purposes of this paragraph, the terms "abuse" and "fraud"
15 have the meanings as provided in s. 409.913. The agency must
16 refer incidents of suspected fraud, abuse, overutilization and
17 duplicative utilization, and underutilization or inappropriate
18 denial of services to the appropriate regulatory agency.
19 (x) To develop and provide actuarial and benefit
20 design analyses that indicate the effect on capitation rates
21 and benefits offered in the pilot program over a prospective
22 5-year period based on the following assumptions:
23 1. Growth in capitation rates which is limited to the
24 estimated growth rate in general revenue.
25 2. Growth in capitation rates which is limited to the
26 average growth rate over the last 3 years in per-recipient
27 Medicaid expenditures.
28 3. Growth in capitation rates which is limited to the
29 growth rate of aggregate Medicaid expenditures between the
30 2003-2004 fiscal year and the 2004-2005 fiscal year.
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1 (y) To develop a mechanism to require capitated
2 managed care plans to reimburse qualified emergency service
3 providers, including, but not limited to, ambulance services,
4 in accordance with ss. 409.908 and 409.9128. The pilot program
5 must include a provision for continuing fee-for-service
6 payments for emergency services, including but not limited to,
7 individuals who access ambulance services or emergency
8 departments and who are subsequently determined to be eligible
9 for Medicaid services.
10 (z) To develop a system whereby school districts
11 participating in the certified school match program pursuant
12 to ss. 409.908(21) and 1011.70 shall be reimbursed by
13 Medicaid, subject to the limitations of s. 1011.70(1), for a
14 Medicaid-eligible child participating in the services as
15 authorized in s. 1011.70, as provided for in s. 409.9071,
16 regardless of whether the child is enrolled in a capitated
17 managed care network. Capitated managed care networks must
18 make a good-faith effort to execute agreements with school
19 districts regarding the coordinated provision of services
20 authorized under s. 1011.70. County health departments
21 delivering school-based services pursuant to ss. 381.0056 and
22 381.0057 must be reimbursed by Medicaid for the federal share
23 for a Medicaid-eligible child who receives Medicaid-covered
24 services in a school setting, regardless of whether the child
25 is enrolled in a capitated managed care network. Capitated
26 managed care networks must make a good-faith effort to execute
27 agreements with county health departments regarding the
28 coordinated provision of services to a Medicaid-eligible
29 child. To ensure continuity of care for Medicaid patients, the
30 agency, the Department of Health, and the Department of
31 Education shall develop procedures for ensuring that a

1 student's capitated managed care network provider receives
2 information relating to services provided in accordance with
3 ss. 381.0056, 381.0057, 409.9071, and 1011.70.
4 (aa) To develop and recommend a mechanism whereby
5 Medicaid recipients who are already enrolled in a managed care
6 plan or the MediPass program in the pilot areas shall be
7 offered the opportunity to change to capitated managed care
8 plans on a staggered basis, as defined by the agency. All
9 Medicaid recipients shall have 30 days in which to make a
10 choice of capitated managed care plans. Those Medicaid
11 recipients who do not make a choice shall be assigned to a
12 capitated managed care plan in accordance with paragraph
13 (4)(a). To facilitate continuity of care for a Medicaid
14 recipient who is also a recipient of Supplemental Security
15 Income (SSI), prior to assigning the SSI recipient to a
16 capitated managed care plan, the agency shall determine
17 whether the SSI recipient has an ongoing relationship with a
18 provider or capitated managed care plan, and if so, the agency
19 shall assign the SSI recipient to that provider or capitated
20 managed care plan where feasible. Those SSI recipients who do
21 not have such a provider relationship shall be assigned to a
22 capitated managed care plan provider in accordance with
23 paragraph (4)(a).
24 (bb) To develop and recommend a service delivery
25 alternative for children having chronic medical conditions
26 which establishes a medical home project to provide primary
27 care services to this population. The project shall provide
28 community-based primary care services that are integrated with
29 other subspecialties to meet the medical, developmental, and
30 emotional needs for children and their families. This project
31 shall include an evaluation component to determine impacts on

1 hospitalizations, length of stays, emergency room visits,
2 costs, and access to care, including specialty care and
3 patient, and family satisfaction.
4 (cc) To develop and recommend service delivery
5 mechanisms within capitated managed care plans to provide
6 Medicaid services as specified in ss. 409.905 and 409.906 to
7 persons with developmental disabilities sufficient to meet the
8 medical, developmental, and emotional needs of these persons.
9 (dd) To develop and recommend service delivery
10 mechanisms within capitated managed care plans to provide
11 Medicaid services as specified in ss. 409.905 and 409.906 to
12 Medicaid-eligible children in foster care. These services must
13 be coordinated with community-based care providers as
14 specified in s. 409.1675, where available, and be sufficient
15 to meet the medical, developmental, and emotional needs of
16 these children.
17 (4)(a) A Medicaid recipient in the pilot area who is
18 not currently enrolled in a capitated managed care plan upon
19 implementation is not eligible for services as specified in
20 ss. 409.905 and 409.906, for the amount of time that the
21 recipient does not enroll in a capitated managed care network.
22 If a Medicaid recipient has not enrolled in a capitated
23 managed care plan within 30 days after eligibility, the agency
24 shall assign the Medicaid recipient to a capitated managed
25 care plan based on the assessed needs of the recipient as
26 determined by the agency. When making assignments, the agency
27 shall take into account the following criteria:
28 1. A capitated managed care network has sufficient
29 network capacity to meet the need of members.
30 2. The capitated managed care network has previously
31 enrolled the recipient as a member, or one of the capitated

1 managed care network's primary care providers has previously
2 provided health care to the recipient.
3 3. The agency has knowledge that the member has
4 previously expressed a preference for a particular capitated
5 managed care network as indicated by Medicaid fee-for-service
6 claims data, but has failed to make a choice.
7 4. The capitated managed care network's primary care
8 providers are geographically accessible to the recipient's
9 residence.
10 (b) When more than one capitated managed care network
11 provider meets the criteria specified in paragraph (3)(h), the
12 agency shall make recipient assignments consecutively by
13 family unit.
14 (c) The agency may not engage in practices that are
15 designed to favor one capitated managed care plan over another
16 or that are designed to influence Medicaid recipients to
17 enroll in a particular capitated managed care network in order
18 to strengthen its particular fiscal viability.
19 (d) After a recipient has made a selection or has been
20 enrolled in a capitated managed care network, the recipient
21 shall have 90 days in which to voluntarily disenroll and
22 select another capitated managed care network. After 90 days,
23 no further changes may be made except for cause. Cause shall
24 include, but not be limited to, poor quality of care, lack of
25 access to necessary specialty services, an unreasonable delay
26 or denial of service, inordinate or inappropriate changes of
27 primary care providers, service access impairments due to
28 significant changes in the geographic location of services, or
29 fraudulent enrollment. The agency may require a recipient to
30 use the capitated managed care network's grievance process as
31 specified in paragraph (3)(g) prior to the agency's

1 determination of cause, except in cases in which immediate
2 risk of permanent damage to the recipient's health is alleged.
3 The grievance process, when used, must be completed in time to
4 permit the recipient to disenroll no later than the first day
5 of the second month after the month the disenrollment request
6 was made. If the capitated managed care network, as a result
7 of the grievance process, approves an enrollee's request to
8 disenroll, the agency is not required to make a determination
9 in the case. The agency must make a determination and take
10 final action on a recipient's request so that disenrollment
11 occurs no later than the first day of the second month after
12 the month the request was made. If the agency fails to act
13 within the specified timeframe, the recipient's request to
14 disenroll is deemed to be approved as of the date agency
15 action was required. Recipients who disagree with the agency's
16 finding that cause does not exist for disenrollment shall be
17 advised of their right to pursue a Medicaid fair hearing to
18 dispute the agency's finding.
19 (e) The agency shall apply for federal waivers from
20 the Centers for Medicare and Medicaid Services to lock
21 eligible Medicaid recipients into a capitated managed care
22 network for 12 months after an open enrollment period. After
23 12 months of enrollment, a recipient may select another
24 capitated managed care network. However, nothing shall prevent
25 a Medicaid recipient from changing primary care providers
26 within the capitated managed care network during the 12-month
27 period.
28 (f) The agency shall apply for federal waivers from
29 the Centers for Medicare and Medicaid Services to allow
30 recipients to purchase health care coverage through an
31 employer-sponsored health insurance plan instead of through a

1 Medicaid-certified plan. This provision shall be known as the
2 opt-out option.
3 1. A recipient who chooses the Medicaid opt-out option
4 shall have an opportunity for a specified period of time, as
5 authorized under a waiver granted by the Centers for Medicare
6 and Medicaid Services, to select and enroll in a
7 Medicaid-certified plan. If the recipient remains in the
8 employer-sponsored plan after the specified period, the
9 recipient shall remain in the opt-out program for at least 1
10 year or until the recipient no longer has access to
11 employer-sponsored coverage, until the employer's open
12 enrollment period for a person who opts out in order to
13 participate in employer-sponsored coverage, or until the
14 person is no longer eligible for Medicaid, whichever time
15 period is shorter.
16 2. Notwithstanding any other provision of this
17 section, coverage, cost sharing, and any other component of
18 employer-sponsored health insurance shall be governed by
19 applicable state and federal laws.
20 (5) This section does not authorize the agency to
21 implement any provision of s. 1115 of the Social Security Act
22 experimental, pilot, or demonstration project waiver to reform
23 the state Medicaid program in any part of the state other than
24 the two geographic areas specified in this section unless
25 approved by the Legislature.
26 (6) The agency shall develop and submit for approval
27 applications for waivers of applicable federal laws and
28 regulations as necessary to implement the managed care pilot
29 project as defined in this section. The agency shall post all
30 waiver applications under this section on its Internet website
31 30 days before submitting the applications to the United

1 States Centers for Medicare and Medicaid Services. All waiver
2 applications shall be provided for review and comment to the
3 appropriate committees of the Senate and House of
4 Representatives for at least 10 working days prior to
5 submission. All waivers submitted to and approved by the
6 United States Centers for Medicare and Medicaid Services under
7 this section must be approved by the Legislature. Federally
8 approved waivers must be submitted to the President of the
9 Senate and the Speaker of the House of Representatives for
10 referral to the appropriate legislative committees. The
11 appropriate committees shall recommend whether to approve the
12 implementation of any waivers to the Legislature as a whole.
13 The agency shall submit a plan containing a recommended
14 timeline for implementation of any waivers and budgetary
15 projections of the effect of the pilot program under this
16 section on the total Medicaid budget for the 2006-2007 through
17 2009-2010 state fiscal years. This implementation plan shall
18 be submitted to the President of the Senate and the Speaker of
19 the House of Representatives at the same time any waivers are
20 submitted for consideration by the Legislature.
21 (7) Upon review and approval of the applications for
22 waivers of applicable federal laws and regulations to
23 implement the managed care pilot program by the Legislature,
24 the agency may initiate adoption of rules pursuant to ss.
25 120.536(1) and 120.54 to implement and administer the managed
26 care pilot program as provided in this section.
27 Section 3. The Office of Program Policy Analysis and
28 Government Accountability, in consultation with the Auditor
29 General, shall comprehensively evaluate the two managed care
30 pilot programs created under section 409.91211, Florida
31 Statutes. The evaluation shall begin with the implementation

1 of the managed care model in the pilot areas and continue for
2 24 months after the two pilot programs have enrolled Medicaid
3 recipients and started providing health care services. The
4 evaluation must include assessments of cost savings; consumer
5 education, choice, and access to services; coordination of
6 care; and quality of care by each eligibility category and
7 managed care plan in each pilot site. The evaluation must
8 describe administrative or legal barriers to the
9 implementation and operation of each pilot program and include
10 recommendations regarding statewide expansion of the managed
11 care pilot programs. The office shall submit an evaluation
12 report to the Governor, the President of the Senate, and the
13 Speaker of the House of Representatives no later than June 30,
14 2008.
15 Section 4. Section 409.9062, Florida Statutes, is
16 amended to read:
17 409.9062 Lung transplant services for Medicaid
18 recipients.--Subject to the availability of funds and subject
19 to any limitations or directions provided for in the General
20 Appropriations Act or chapter 216, the Agency for Health Care
21 Administration Medicaid program shall pay for medically
22 necessary lung transplant services for Medicaid recipients.
23 These payments must be used to reimburse approved lung
24 transplant facilities a global fee for providing lung
25 transplant services to Medicaid recipients.
26 Section 5. The sums of $401,098 from the General
27 Revenue Fund and $593,058 from the Medical Care Trust Fund are
28 appropriated to the Agency for Health Care Administration for
29 the purpose of implementing section 4 during the 2005-2006
30 fiscal year.
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1 Section 6. Paragraphs (a) and (j) of subsection (2) of
2 section 409.9122, Florida Statutes, are amended to read:
3 409.9122 Mandatory Medicaid managed care enrollment;
4 programs and procedures.--
5 (2)(a) The agency shall enroll in a managed care plan
6 or MediPass all Medicaid recipients, except those Medicaid
7 recipients who are: in an institution; enrolled in the
8 Medicaid medically needy program; or eligible for both
9 Medicaid and Medicare. Upon enrollment, individuals will be
10 able to change their managed care option during the 90-day opt
11 out period required by federal Medicaid regulations. The
12 agency is authorized to seek the necessary Medicaid state plan
13 amendment to implement this policy. However, to the extent
14 permitted by federal law, the agency may enroll in a managed
15 care plan or MediPass a Medicaid recipient who is exempt from
16 mandatory managed care enrollment, provided that:
17 1. The recipient's decision to enroll in a managed
18 care plan or MediPass is voluntary;
19 2. If the recipient chooses to enroll in a managed
20 care plan, the agency has determined that the managed care
21 plan provides specific programs and services which address the
22 special health needs of the recipient; and
23 3. The agency receives any necessary waivers from the
24 federal <u>Centers for Medicare and Medicaid Services</u> ~~Health Care
25 Financing Administration~~.
26
27 The agency shall develop rules to establish policies by which
28 exceptions to the mandatory managed care enrollment
29 requirement may be made on a case-by-case basis. The rules
30 shall include the specific criteria to be applied when making
31 a determination as to whether to exempt a recipient from

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1 mandatory enrollment in a managed care plan or MediPass.
2 School districts participating in the certified school match
3 program pursuant to ss. 409.908(21) and 1011.70 shall be
4 reimbursed by Medicaid, subject to the limitations of s.
5 1011.70(1), for a Medicaid-eligible child participating in the
6 services as authorized in s. 1011.70, as provided for in s.
7 409.9071, regardless of whether the child is enrolled in
8 MediPass or a managed care plan. Managed care plans shall make
9 a good faith effort to execute agreements with school
10 districts regarding the coordinated provision of services
11 authorized under s. 1011.70. County health departments
12 delivering school-based services pursuant to ss. 381.0056 and
13 381.0057 shall be reimbursed by Medicaid for the federal share
14 for a Medicaid-eligible child who receives Medicaid-covered
15 services in a school setting, regardless of whether the child
16 is enrolled in MediPass or a managed care plan. Managed care
17 plans shall make a good faith effort to execute agreements
18 with county health departments regarding the coordinated
19 provision of services to a Medicaid-eligible child. To ensure
20 continuity of care for Medicaid patients, the agency, the
21 Department of Health, and the Department of Education shall
22 develop procedures for ensuring that a student's managed care
23 plan or MediPass provider receives information relating to
24 services provided in accordance with ss. 381.0056, 381.0057,
25 409.9071, and 1011.70.
26 (j) The agency shall apply for a federal waiver from
27 the Centers for Medicare and Medicaid Services ~~Health Care~~
28 ~~Financing Administration~~ to lock eligible Medicaid recipients
29 into a managed care plan or MediPass for 12 months after an
30 open enrollment period. After 12 months' enrollment, a
31 recipient may select another managed care plan or MediPass

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1 provider. However, nothing shall prevent a Medicaid recipient
2 from changing primary care providers within the managed care
3 plan or MediPass program during the 12-month period.
4 Section 7. Subsection (2) of section 409.913, Florida
5 Statutes, is amended, and subsection (36) is added to that
6 section, to read:
7 409.913 Oversight of the integrity of the Medicaid
8 program.--The agency shall operate a program to oversee the
9 activities of Florida Medicaid recipients, and providers and
10 their representatives, to ensure that fraudulent and abusive
11 behavior and neglect of recipients occur to the minimum extent
12 possible, and to recover overpayments and impose sanctions as
13 appropriate. Beginning January 1, 2003, and each year
14 thereafter, the agency and the Medicaid Fraud Control Unit of
15 the Department of Legal Affairs shall submit a joint report to
16 the Legislature documenting the effectiveness of the state's
17 efforts to control Medicaid fraud and abuse and to recover
18 Medicaid overpayments during the previous fiscal year. The
19 report must describe the number of cases opened and
20 investigated each year; the sources of the cases opened; the
21 disposition of the cases closed each year; the amount of
22 overpayments alleged in preliminary and final audit letters;
23 the number and amount of fines or penalties imposed; any
24 reductions in overpayment amounts negotiated in settlement
25 agreements or by other means; the amount of final agency
26 determinations of overpayments; the amount deducted from
27 federal claiming as a result of overpayments; the amount of
28 overpayments recovered each year; the amount of cost of
29 investigation recovered each year; the average length of time
30 to collect from the time the case was opened until the
31 overpayment is paid in full; the amount determined as

uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments.

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

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

1 Section 8. The Agency for Health Care Administration
2 shall submit to the Legislature by December 15, 2005, a report
3 on the legal and administrative barriers to enforcing section
4 409.9081, Florida Statutes. The report must describe how many
5 services require copayments, which providers collect
6 copayments, and the total amount of copayments collected from
7 recipients for all services required under section 409.9081,
8 Florida Statutes, by provider type for the 2001-2002 through
9 2004-2005 fiscal years. The agency shall recommend a mechanism
10 to enforce the requirement for Medicaid recipients to make
11 copayments which does not shift the copayment amount to the
12 provider. The agency shall also identify the federal or state
13 laws or regulations that permit Medicaid recipients to declare
14 impoverishment in order to avoid paying the copayment and
15 extent to which these statements of impoverishment are
16 verified. If claims of impoverishment are not currently
17 verified, the agency shall recommend a system for such
18 verification. The report must also identify any other
19 cost-sharing measures that could be imposed on Medicaid
20 recipients.
21 Section 9. The Agency for Health Care Administration
22 shall submit to the Legislature by January 15, 2006,
23 recommendations to ensure that Medicaid is the payer of last
24 resort as required by section 409.910, Florida Statutes. The
25 report must identify the public and private entities that are
26 liable for primary payment of health care services and
27 recommend methods to improve enforcement of third-party
28 liability responsibility and repayment of benefits to the
29 state Medicaid program. The report must estimate the potential
30 recoveries that may be achieved through third-party liability
31 efforts if administrative and legal barriers are removed. The

1 report must recommend whether modifications to the agency's
2 contingency-fee contract for third-party liability could
3 enhance third-party liability for benefits provided to
4 Medicaid recipients.
5 Section 10. By January 15, 2006, the Office of Program
6 Policy Analysis and Government Accountability shall submit to
7 the Legislature a study of the long-term care community
8 diversion pilot project authorized under sections
9 430.701-430.709, Florida Statutes. The study may be conducted
10 by staff of the Office of Program Policy Analysis and
11 Government Accountability or by a consultant obtained through
12 a competitive bid pursuant to the provisions of chapter 287,
13 Florida Statutes. The study must use a statistically-valid
14 methodology to assess the percent of persons served in the
15 project over a 2-year period who would have required Medicaid
16 nursing home services without the diversion services, which
17 services are most frequently used, and which services are
18 least frequently used. The study must determine whether the
19 project is cost-effective or is an expansion of the Medicaid
20 program because a preponderance of the project enrollees would
21 not have required Medicaid nursing home services within a
22 2-year period regardless of the availability of the project or
23 that the enrollees could have been safely served through
24 another Medicaid program at a lower cost to the state.
25 Section 11. The Agency for Health Care Administration
26 shall identify how many individuals in the long-term care
27 diversion programs who receive care at home have a
28 patient-responsibility payment associated with their
29 participation in the diversion program. If no system is
30 available to assess this information, the agency shall
31 determine the cost of creating a system to identify and

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1 collect these payments and whether the cost of developing a
2 system for this purpose is offset by the amount of
3 patient-responsibility payments which could be collected with
4 the system. The agency shall report this information to the
5 Legislature by December 1, 2005.
6 Section 12. The Office of Program Policy Analysis and
7 Government Accountability shall conduct a study of state
8 programs that allow non-Medicaid eligible persons under a
9 certain income level to buy into the Medicaid program as if it
10 was private insurance. The study shall examine Medicaid buy-in
11 programs in other states to determine if there are any models
12 that can be implemented in Florida which would provide access
13 to uninsured Floridians and what effect this program would
14 have on Medicaid expenditures based on the experience of
15 similar states. The study must also examine whether the
16 Medically Needy program could be redesigned to be a Medicaid
17 buy-in program. The study must be submitted to the Legislature
18 by January 1, 2006.
19 Section 13. The Office of Program Policy Analysis and
20 Government Accountability, in consultation with the Office of
21 Attorney General, Medicaid Fraud Control Unit and the Auditor
22 General, shall conduct a study to examine issues related to
23 the amount of state and federal dollars lost due to fraud and
24 abuse in the Medicaid prescription drug program. The study
25 shall focus on examining whether pharmaceutical manufacturers
26 and their affiliates and wholesale pharmaceutical
27 manufacturers and their affiliates that participate in the
28 Medicaid program in this state, with respect to rebates for
29 prescription drugs, are inflating the average wholesale price
30 that is used in determining how much the state pays for
31 prescription drugs for Medicaid recipients. The study shall

1 also focus on examining whether the manufacturers and their
2 affiliates are committing other deceptive pricing practices
3 with regard to federal and state rebates for prescription
4 drugs in the Medicaid program in this state. The study,
5 including findings and recommendations, shall be submitted to
6 the Governor, the President of the Senate, the Speaker of the
7 House of Representatives, the Minority Leader of the Senate,
8 and the Minority Leader of the House of Representatives by
9 January 1, 2006.
10 Section 14. The sums of $7,129,241 in recurring
11 General Revenue Funds, $9,076,875 in nonrecurring General
12 Revenue Funds, $8,608,242 in recurring funds from the
13 Administrative Trust Fund, and $9,076,874 in nonrecurring
14 funds from the Administrative Trust Fund are appropriated and
15 11 full time equivalent positions are authorized for the
16 purpose of implementing this act.
17 Section 15. The amendments made to section 393.0661,
18 Florida Statutes, by the Conference Committee Report on
19 Committee Substitute for Committee Substitute for Senate Bill
20 404 are repealed.
21 Section 16. The amendments made to section 409.907,
22 Florida Statutes, by the Conference Committee Report on
23 Committee Substitute for Committee Substitute for Senate Bill
24 404 are repealed.
25 Section 17. The amendments made to the introductory
26 provision only of section 409.908, Florida Statutes, by the
27 Conference Committee Report on Committee Substitute for
28 Committee Substitute for Senate Bill 404 are repealed.
29 Section 18. Section 409.9082, Florida Statutes, as
30 created by the Conference Committee Report on Committee
31

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Substitute for Committee Substitute for Senate Bill 404, is repealed.

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

Section 20. Subsection (2) of section 409.9124, Florida Statutes, as amended by section 18 of the Conference Committee Report on Committee Substitute for Committee Substitute for Senate Bill 404 is amended, and subsection (6) is added to that section, to read:

409.9124 Managed care reimbursement.--

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

(6) For the 2005-2006 fiscal year only, the agency shall make an additional adjustment in calculating the capitation payments to prepaid health plans, excluding prepaid mental health plans. This adjustment must result in an increase of 2.8 percent in the average per-member, per-month rate paid to prepaid health plans, excluding prepaid mental

1 health plans, which are funded from Specific Appropriations
2 225 and 226 in the 2005-2006 General Appropriations Act.
3 Section 21. The Senate Select Committee on Medicaid
4 Reform shall study how provider rates are established and
5 modified, how provider agreements and administrative
6 rulemaking effect those rates, the discretion allowed by
7 federal law for the setting of rates by the state, and the
8 impact of litigation on provider rates. The committee shall
9 issue a report containing recommendations by March 1, 2006, to
10 the Governor, the President of the Senate, and the Speaker of
11 the House of Representatives.
12 Section 22. This act shall take effect July 1, 2005.
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