Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative(s) Bean offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

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

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

(3)(a) The agency shall adopt rules providing minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning January 1, 2003~~, and increasing to 2.9 hours of direct care per resident per day beginning July 1, 2006~~. Beginning January 1, 2002, no facility shall staff below one certified nursing assistant per

20 residents, and a minimum licensed nursing staffing of 1.0 hour of direct resident care per resident per day but never below one licensed nurse per 40 residents. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants only if they provide nursing assistance services to residents on a full-time basis. Each nursing home must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

Section 2. Subsection (5) of section 409.904, Florida Statutes, is amended to read:

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(5) Subject to specific federal authorization, a ~~postpartum~~ woman living in a family that has an income that is at or below 185 percent of the most current federal poverty level is eligible for family planning services as specified in s. 409.905(3) for a period of up to 24 months following a loss of Medicaid benefits ~~pregnancy for which Medicaid paid for pregnancy-related services~~.

Section 3. Paragraph (d) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency

from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(d) The agency shall implement a hospitalist program in certain high-volume participating hospitals, select counties, or statewide. The program shall require hospitalists to ~~authorize and~~ manage Medicaid recipients' hospital admissions and lengths of stay. Individuals who are dually eligible for Medicare and Medicaid are exempted from this requirement. Medicaid participating physicians and other practitioners with hospital admitting privileges shall coordinate and review admissions of Medicaid recipients with the hospitalist. The agency may competitively bid a contract for selection of a qualified organization to provide hospitalist services. The qualified organization shall employ board certified physicians who are full-time dedicated employees of the contractor and have no outside practice. ~~Where used, the hospitalist program shall replace the existing hospital utilization review program. The~~

~~agency is authorized to seek federal waivers to implement this program.~~

Section 4. Paragraph (b) of subsection (1) and subsection (23) of section 409.906, Florida Statutes, are amended to read:

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

(1) ADULT DENTAL SERVICES.--

(b) Beginning January 1, 2005, the agency may pay for <u>partial dentures and full</u> dentures, the procedures required to

seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is 21 years of age or older.

(23) ~~CHILDREN'S~~ VISUAL SERVICES.--The agency may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient ~~younger than 21 years of age,~~ if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist. Eyeglasses for adult recipients shall be limited to two pairs per year per recipient, except a third pair may be provided after prior authorization.

Section 5. Paragraph (a) of subsection (9) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.--The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(9) Upon receipt of a completed, signed, and dated application, and completion of any necessary background investigation and criminal history record check, the agency must either:

(a) Enroll the applicant as a Medicaid provider ~~no earlier than the effective date of the approval of the provider application. With respect to providers who were recently granted~~

~~a change of ownership and those who primarily provide emergency medical services transportation or emergency services and care pursuant to s. 395.1041 or s. 401.45, or services provided by entities under s. 409.91255, and out of state providers,~~ upon approval of the provider application.~~,~~ The enrollment effective date shall be ~~of approval is considered to be~~ the date the agency receives the provider application. Payment for any claims for services provided to Medicaid recipients between the date of receipt of the application and the date of approval is contingent on applying any and all applicable audits and edits contained in the agency's claims adjudication and payment processing systems; or

Section 6. Paragraph (c) of subsection (1) of section 409.9081, Florida Statutes, is amended to read:

409.9081 Copayments.--

(1) The agency shall require, subject to federal regulations and limitations, each Medicaid recipient to pay at the time of service a nominal copayment for the following Medicaid services:

(c) Hospital emergency department visits for nonemergency care: 5 percent of up to the first $300 of the Medicaid payment for emergency room services, not to exceed $15 ~~for each emergency department visit~~.

Section 7. Subsections (2), (3), and (4) of section 409.911, Florida Statutes, are amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this

section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

(a) The average of the ~~1998, 1999, and~~ 2000, 2001, and 2002 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2006-2007 ~~2004-2005~~ state fiscal year ~~and the average of the 1999, 2000, and 2001 audited disproportionate share data to determine the Medicaid days and charity care for the 2005-2006 state fiscal year~~.

(b) If the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share data as noted in paragraph (a) for a hospital, the agency shall use the average of the years of the audited disproportionate share data as noted in paragraph (a) which is available.

(c) In accordance with s. 1923(b) of the Social Security Act, a hospital with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater shall qualify for reimbursement.

(3) Hospitals that qualify for a disproportionate share payment solely under paragraph (2)(c) shall have their payment calculated in accordance with the following formulas:

DSHP = (HMD/TMSD) x $1 million

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSD = total state Medicaid days.

Any funds not allocated to hospitals qualifying under this section shall be redistributed to the non-state government owned or operated hospitals with greater than 3,100 ~~3,300~~ Medicaid days.

(4) The following formulas shall be used to pay disproportionate share dollars to public hospitals:

(a) For state mental health hospitals:

DSHP = (HMD/TMDMH) x TAAMH

shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program.

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TMDHH = total Medicaid days for state mental health hospitals.

TAAMH = total amount available for mental health hospitals.

(b) For non-state government owned or operated hospitals with 3,100 ~~3,300~~ or more Medicaid days:

$$DSHP = [(.82 \times HCCD/TCCD) + (.18 \times HMD/TMD)] \times TAAPH$$

$$TAAPH = TAA - TAAMH$$

Where:

TAA = total available appropriation.

TAAPH = total amount available for public hospitals.

DSHP = disproportionate share hospital payments.

HMD = hospital Medicaid days.

TMD = total state Medicaid days for public hospitals.

HCCD = hospital charity care dollars.

TCCD = total state charity care dollars for public non-state hospitals.

~~1. For the 2005-2006 state fiscal year only, the DSHP for the public nonstate hospitals shall be computed using a weighted average of the disproportionate share payments for the 2004-2005 state fiscal year which uses an average of the 1998, 1999, and 2000 audited disproportionate share data and the disproportionate share payments for the 2005-2006 state fiscal year as computed using the formula above and using the average of the 1999, 2000, and 2001 audited disproportionate share data. The final DSHP for the public nonstate hospitals shall be~~

~~computed as an average using the calculated payments for the 2005-2006 state fiscal year weighted at 65 percent and the disproportionate share payments for the 2004-2005 state fiscal year weighted at 35 percent.~~

~~2.~~ The TAAPH shall be reduced by $6,365,257 before computing the DSHP for each public hospital. The $6,365,257 shall be distributed equally between the public hospitals that are also designated statutory teaching hospitals.

(c) For non-state government owned or operated hospitals with less than 3,100 ~~3,300~~ Medicaid days, a total of $750,000 shall be distributed equally among these hospitals.

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

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year 2006-2007 ~~2005-2006~~, the agency shall ~~not~~ distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching

hospitals under the teaching hospital disproportionate share program. The funds provided for statutorily defined teaching hospitals shall be distributed in the same proportion as the state fiscal year 2003-2004 teaching hospital disproportionate share funds were distributed. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

(1) On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

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

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

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

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

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

(c) A service index that comprises three components:

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

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

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

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

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

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

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

409.9117 Primary care disproportionate share program.--For the state fiscal year 2006-2007 ~~2005-2006~~, the agency shall not distribute moneys under the primary care disproportionate share program.

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

(b) Ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a

prepaid capitated arrangement and who are in need of access to such physicians.

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.

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

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

protect the public health within the agreed geopolitical boundaries.

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

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

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

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

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

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

Section 10. Paragraph (b) of subsection (4) and subsection (44) of section 409.912, Florida Statutes, are amended, and subsection (53) is added to that section, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify

trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in 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 seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of 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., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, 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 Medicaid managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. 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 reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

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

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

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to

all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts shall be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment

shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under the provisions of s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

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

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

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

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

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider shall not

be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

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

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

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

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

(44) The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(f) ~~(h)~~, whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which may ~~shall~~ be ~~actuarially~~ adjusted for health status ~~case mix, model, and service area~~. The agency shall conduct actuarially sound adjustments for health status ~~audits adjusted for case mix and model~~ in order to ensure such cost-effectiveness and shall publish the ~~audit~~ results on its Internet website and submit the ~~audit~~ results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December

31 of each year. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(53) In accordance with s. 430.705 and 42 C.F.R. s. 438, Medicaid capitation payments for managed long-term care programs shall be risk adjusted by plan and reflect members' level of chronic illness, functional limitations, and risk of institutional placement, as determined by expenditures for a comparable fee-for-service population. Payments for Medicaid home and community-based services shall be actuarially equivalent to plan experience.

Section 11. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 ~~40~~ percent in MediPass and 65 ~~60~~ percent in managed care plans, of all those eligible to choose managed care, is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 ~~40~~ percent and 65 ~~60~~ percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions

shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g), Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 ~~40~~ percent in MediPass and 65 ~~60~~ percent in managed care plans, of all those eligible to choose managed care, is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 ~~40~~ percent and 65 ~~60~~ percent proportion, respectively. In service areas 1 and 6 of the Agency for Health Care Administration where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive

provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

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

Section 12. Paragraph (b) of subsection (5) of section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to

be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

2. Arrange for the collection of any voluntary contributions to provide for payment of premiums for children who are not eligible for medical assistance under Title XXI of the Social Security Act. Each fiscal year, the corporation shall establish a local match policy for the enrollment of non-Title-XXI-eligible children in the Healthy Kids program. By May 1 of each year, the corporation shall provide written notification of the amount to be remitted to the corporation for the following fiscal year under that policy. Local match sources may include, but are not limited to, funds provided by municipalities, counties, school boards, hospitals, health care providers, charitable organizations, special taxing districts, and private organizations. The minimum local match cash contributions required each fiscal year and local match credits shall be determined by the General Appropriations Act. The corporation shall calculate a county's local match rate based upon that county's percentage of the state's total non-Title-XXI expenditures as reported in the corporation's most recently audited financial statement. In awarding the local match credits, the corporation may consider factors including, but not limited to, population density, per capita income, and existing child-health-related expenditures and services. <u>If local match amounts collected exceed expenditures during any fiscal year, including the 2005-2006 fiscal year, the corporation shall return unspent local funds collected based on a formula developed by the corporation.</u>

3. Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional coverage in contributing counties under Title XXI.

4. Establish the administrative and accounting procedures for the operation of the corporation.

5. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

6. Determine eligibility for children seeking to participate in the Title XXI-funded components of the Florida KidCare program consistent with the requirements specified in s. 409.814, as well as the non-Title-XXI-eligible children as provided in subsection (3).

7. Establish procedures under which providers of local match to, applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.

8. Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

9. Establish enrollment criteria which shall include penalties or waiting periods of not fewer than 60 days for

reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums.

10. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

11. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

12. Develop and implement a plan to publicize the Florida Healthy Kids Corporation, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

13. Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation.

14. Provide a report annually to the Governor, Chief Financial Officer, Commissioner of Education, Senate President, Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives.

15. Establish benefit packages which conform to the provisions of the Florida KidCare program, as created in ss. 409.810-409.820.

Section 13. Subsection (4) of section 430.705, Florida Statutes, is amended to read:

430.705 Implementation of the long-term care community diversion pilot projects.--

(4) Pursuant to 42 C.F.R. s. 438.6(c), the agency, in consultation with the department, shall annually reevaluate and recertify the capitation rates for the diversion pilot projects. The agency, in consultation with the department, shall secure the utilization and cost data for Medicaid and Medicare beneficiaries served by the program which shall be used in developing rates for the diversion pilot projects. <u>The capitation rates shall be risk adjusted by plan and reflect members' level of chronic illness, functional limitations, and risk of institutional placement, as determined by expenditures for a comparable fee-for-service population. Payments for Medicaid home and community-based services shall be actuarially equivalent to plan experience.</u>

Section 14. This act shall take effect July 1, 2006.

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

Remove the entire title and insert:

A bill to be entitled

An act relating to health care; amending s. 400.23, F.S.; revising minimum staffing requirements for nursing homes; amending s. 409.904, F.S.; revising requirements relating to eligibility of certain women for family planning services; amending s. 409.905, F.S.; revising requirements for the hospitalist program; removing a provision authorizing the Agency for Health Care Administration to seek certain waivers to implement the program; amending s. 409.906, F.S.; revising provisions relating to optional adult dental and visual services covered by Medicaid; amending s. 409.907, F.S.; revising the enrollment effective date for Medicaid providers; providing procedures for payment for certain claims for services; amending s. 409.9081, F.S.; revising the limitation on Medicaid recipient copayments for emergency room services; amending s. 409.911, F.S., relating to the hospital disproportionate share program; revising the method for calculating disproportionate share payments to hospitals; deleting obsolete provisions; amending s. 409.9113, F.S.; providing guidelines for distribution of disproportionate share funds to certain teaching hospitals; amending s. 409.9117, F.S., relating to the primary care disproportionate share program; revising the time period during which the agency shall not distribute certain

moneys; amending s. 409.912, F.S., relating to cost-effective purchasing of health care; deleting an obsolete provision requiring a certain percentage of capitation paid to managed care plans to be expended for behavioral health services; providing that adjustments for health status be considered in agency evaluations of the cost-effectiveness of Medicaid managed care plans; providing requirements for Medicaid capitation payments for managed long-term care programs and payments for Medicaid home and community-based services; amending s. 409.9122, F.S.; revising enrollment limits for Medicaid recipients who are subject to mandatory assignment to managed care plans and MediPass; amending s. 624.91, F.S.; requiring the Florida Healthy Kids Corporation to return certain unspent funds based on a formula developed by the corporation; amending s. 430.705, F.S., relating to implementation of the long-term care community diversion pilot projects; providing requirements for Medicaid capitation payments for managed long-term care programs and payments for Medicaid home and community-based services; providing an effective date.