Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate . House

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1 The Conference Committee on HB 5007 offered the following:

2

3 **Conference Committee Amendment (with title amendment)**

4 Remove everything after the enacting clause and insert:

5 Section 1. Subsection (16) of section 391.026, Florida

6 Statutes, is amended to read:

7 391.026 Powers and duties of the department.--The

8 department shall have the following powers, duties, and

9 responsibilities:

10 (16) To receive and manage health care premiums,

11 capitation payments, and funds from federal, state, local, and

12 private entities for the program. The department may contract

13 with a third-party administrator for processing claims,

14 monitoring medical expenses, and other related services

15 necessary to the efficient and cost-effective operation of the

16 Children's Medical Services network. The department is

17 authorized to maintain a minimum reserve for the Children's
18 Medical Services network in an amount that is the greater of:
19 (a) Ten percent of total projected expenditures for Title
20 XIX-funded and Title XXI-funded children; or
21 (b) Two percent of total annualized payments from the
22 Agency for Health Care Administration for Title XIX and Title
23 XXI of the Social Security Act.
24 Section 2. Paragraph (e) of subsection (15) of section
25 400.141, Florida Statutes, is amended to read:
26 400.141 Administration and management of nursing home
27 facilities.--Every licensed facility shall comply with all
28 applicable standards and rules of the agency and shall:
29 (15) Submit semiannually to the agency, or more frequently
30 if requested by the agency, information regarding facility
31 staff-to-resident ratios, staff turnover, and staff stability,
32 including information regarding certified nursing assistants,
33 licensed nurses, the director of nursing, and the facility
34 administrator. For purposes of this reporting:
35 (e) A nursing facility which does not have a conditional
36 license may be cited for failure to comply with the standards in
37 s. 400.23(3)(a)1.a. only if it has failed to meet those
38 standards on 2 consecutive days or if it has failed to meet at
39 least 97 percent of those standards on any one day.
40
41 Nothing in this section shall limit the agency's ability to
42 impose a deficiency or take other actions if a facility does not
43 have enough staff to meet the residents' needs.
44

Facilities that have been awarded a Gold Seal under the program established in s. 400.235 may develop a plan to provide certified nursing assistant training as prescribed by federal regulations and state rules and may apply to the agency for approval of their program.

Section 3. Paragraph (d) of subsection (5) of section 400.179, Florida Statutes, is amended to read:

400.179 Sale or transfer of ownership of a nursing facility; liability for Medicaid underpayments and overpayments.--

(5) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

(d) Where the transfer involves a facility that has been leased by the transferor:

1. The transferee shall, as a condition to being issued a license by the agency, acquire, maintain, and provide proof to the agency of a bond with a term of 30 months, renewable annually, in an amount not less than the total of 3 months' ~~months~~ Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid at the time of any subsequent annual license

74 renewal, in the amount of 1 ~~2~~ percent of the total of 3 months'
75 Medicaid payments to the facility computed on the basis of the
76 preceding 12-month average Medicaid payments to the facility. If
77 a preceding 12-month average is not available, projected
78 Medicaid payments may be used. The fee shall be deposited into
79 the Health Care Trust Fund and shall be accounted for separately
80 as a Medicaid nursing home overpayment account. These fees shall
81 be used at the sole discretion of the agency to repay nursing
82 home Medicaid overpayments. Payment of this fee shall not
83 release the licensee from any liability for any Medicaid
84 overpayments, nor shall payment bar the agency from seeking to
85 recoup overpayments from the licensee and any other liable
86 party. As a condition of exercising this lease bond alternative,
87 licensees paying this fee must maintain an existing lease bond
88 through the end of the 30-month term period of that bond. The
89 agency is herein granted specific authority to promulgate all
90 rules pertaining to the administration and management of this
91 account, including withdrawals from the account, subject to
92 federal review and approval. This provision shall take effect
93 upon becoming law and shall apply to any leasehold license
94 application. The financial viability of the Medicaid nursing
95 home overpayment account shall be determined by the agency
96 through annual review of the account balance and the amount of
97 total outstanding, unpaid Medicaid overpayments owing from
98 leasehold licensees to the agency as determined by final agency
99 audits.
100 3. The leasehold licensee may meet the bond requirement
101 through other arrangements acceptable to the agency. The agency

102 is herein granted specific authority to promulgate rules
103 pertaining to lease bond arrangements.
104 4. All existing nursing facility licensees, operating the
105 facility as a leasehold, shall acquire, maintain, and provide
106 proof to the agency of the 30-month bond required in
107 subparagraph 1., above, on and after July 1, 1993, for each
108 license renewal.
109 5. It shall be the responsibility of all nursing facility
110 operators, operating the facility as a leasehold, to renew the
111 30-month bond and to provide proof of such renewal to the agency
112 annually at the time of application for license renewal.
113 6. Any failure of the nursing facility operator to
114 acquire, maintain, renew annually, or provide proof to the
115 agency shall be grounds for the agency to deny, cancel, revoke,
116 or suspend the facility license to operate such facility and to
117 take any further action, including, but not limited to,
118 enjoining the facility, asserting a moratorium, or applying for
119 a receiver, deemed necessary to ensure compliance with this
120 section and to safeguard and protect the health, safety, and
121 welfare of the facility's residents. A lease agreement required
122 as a condition of bond financing or refinancing under s. 154.213
123 by a health facilities authority or required under s. 159.30 by
124 a county or municipality is not a leasehold for purposes of this
125 paragraph and is not subject to the bond requirement of this
126 paragraph.
127 Section 4. Paragraph (a) of subsection (3) of section
128 400.23, Florida Statutes, is amended to read:
129 400.23 Rules; evaluation and deficiencies; licensure
130 status.--

131 (3)(a)1. The agency shall adopt rules providing minimum
132 staffing requirements for nursing homes. These requirements
133 shall include, for each nursing home facility:~~,~~
134 a. A minimum certified nursing assistant staffing of ~~2.3~~
135 ~~hours of direct care per resident per day beginning January 1,~~
136 ~~2002, increasing to~~ 2.6 hours of direct care per resident per
137 day beginning January 1, 2003, and increasing to 2.7 ~~2.9~~ hours
138 of direct care per resident per day beginning January 1, 2007
139 ~~July 1, 2006~~. Beginning January 1, 2002, no facility shall staff
140 below one certified nursing assistant per 20 residents, and a
141 minimum licensed nursing staffing of 1.0 hour of direct ~~resident~~
142 care per resident per day but never below one licensed nurse per
143 40 residents.
144 b. Beginning January 1, 2007, a minimum weekly average
145 certified nursing assistant staffing of 2.9 hours of direct care
146 per resident per day. For the purpose of this sub-subparagraph,
147 a week is defined as Sunday through Saturday.
148 2. Nursing assistants employed under s. 400.211(2) may be
149 included in computing the staffing ratio for certified nursing
150 assistants only if their job responsibilities include only
151 nursing-assistant-related duties ~~they provide nursing assistance~~
152 ~~services to residents on a full-time basis~~.
153 3. Each nursing home must document compliance with
154 staffing standards as required under this paragraph and post
155 daily the names of staff on duty for the benefit of facility
156 residents and the public.
157 4. The agency shall recognize the use of licensed nurses
158 for compliance with minimum staffing requirements for certified
159 nursing assistants, provided that the facility otherwise meets

160 the minimum staffing requirements for licensed nurses and that
161 the licensed nurses are performing the duties of a certified
162 nursing assistant. Unless otherwise approved by the agency,
163 licensed nurses counted toward the minimum staffing requirements
164 for certified nursing assistants must exclusively perform the
165 duties of a certified nursing assistant for the entire shift and
166 not also be counted toward the minimum staffing requirements for
167 licensed nurses. If the agency approved a facility's request to
168 use a licensed nurse to perform both licensed nursing and
169 certified nursing assistant duties, the facility must allocate
170 the amount of staff time specifically spent on certified nursing
171 assistant duties for the purpose of documenting compliance with
172 minimum staffing requirements for certified and licensed nursing
173 staff. In no event may the hours of a licensed nurse with dual
174 job responsibilities be counted twice.
175 Section 5. Subsections (12) through (27) of section
176 409.811, Florida Statutes, are renumbered as subsections (11)
177 through (26), respectively, and present subsection (11) of that
178 section is amended to read:
179 409.811 Definitions relating to Florida KidCare Act.--As
180 used in ss. 409.810-409.820, the term:
181 ~~(11) "Enrollment ceiling" means the maximum number of~~
182 ~~children receiving premium assistance payments, excluding~~
183 ~~children enrolled in Medicaid, that may be enrolled at any time~~
184 ~~in the Florida KidCare program. The maximum number shall be~~
185 ~~established annually in the General Appropriations Act or by~~
186 ~~general law.~~
187 Section 6. Subsections (1) and (2) of section 409.8134,
188 Florida Statutes, are amended to read:

189 409.8134 Program ~~enrollment and~~ expenditure ceiling
190 ~~ceilings~~.--
191 (1) Except for the Medicaid program, a ceiling shall be
192 placed on annual federal and state expenditures for ~~and on~~
193 ~~enrollment in~~ the Florida KidCare program as provided each year
194 in the General Appropriations Act.
195 (2) The Florida KidCare program may conduct enrollment at
196 any time throughout the year for the purpose of enrolling
197 children eligible for all program components listed in s.
198 409.813 except Medicaid. The four Florida KidCare administrators
199 shall work together to ensure that the year-round enrollment
200 period is announced statewide. Eligible children shall be
201 enrolled on a first-come, first-served basis using the date the
202 enrollment application is received. Enrollment shall immediately
203 cease when the expenditure ~~enrollment~~ ceiling is reached. Year-
204 round enrollment shall only be held if the Social Services
205 Estimating Conference determines that sufficient federal and
206 state funds will be available to finance the increased
207 enrollment through federal fiscal year 2007. Any individual who
208 is not enrolled must reapply by submitting a new application.
209 The application for the Florida KidCare program shall be valid
210 for a period of 120 days after the date it was received. At the
211 end of the 120-day period, if the applicant has not been
212 enrolled in the program, the application shall be invalid and
213 the applicant shall be notified of the action. The applicant may
214 resubmit the application after notification of the action taken
215 by the program. Except for the Medicaid program, whenever the
216 Social Services Estimating Conference determines that there are
217 presently, or will be by the end of the current fiscal year,

218 insufficient funds to finance the current or projected
219 enrollment in the Florida KidCare program, all additional
220 enrollment must cease and additional enrollment may not resume
221 until sufficient funds are available to finance such enrollment.
222 Section 7. Paragraph (d) of subsection (5) of section
223 409.814, Florida Statutes, is amended to read:
224 409.814 Eligibility.--A child who has not reached 19 years
225 of age whose family income is equal to or below 200 percent of
226 the federal poverty level is eligible for the Florida KidCare
227 program as provided in this section. For enrollment in the
228 Children's Medical Services Network, a complete application
229 includes the medical or behavioral health screening. If,
230 subsequently, an individual is determined to be ineligible for
231 coverage, he or she must immediately be disenrolled from the
232 respective Florida KidCare program component.
233 (5) A child whose family income is above 200 percent of
234 the federal poverty level or a child who is excluded under the
235 provisions of subsection (4) may participate in the Florida
236 KidCare program, excluding the Medicaid program, but is subject
237 to the following provisions:
238 ~~(d) Children described in this subsection are not counted~~
239 ~~in the annual enrollment ceiling for the Florida KidCare~~
240 ~~program.~~
241 Section 8. Paragraphs (c) through (g) of subsection (3) of
242 section 409.818, Florida Statutes, are redesignated as
243 paragraphs (b) through (f), respectively, and present paragraphs
244 (b) and (g) of subsection (3) of that section are amended to
245 read:

246 409.818 Administration.--In order to implement ss.
247 409.810-409.820, the following agencies shall have the following
248 duties:
249 (3) The Agency for Health Care Administration, under the
250 authority granted in s. 409.914(1), shall:
251 ~~(b) Annually calculate the program enrollment ceiling~~
252 ~~based on estimated per child premium assistance payments and the~~
253 ~~estimated appropriation available for the program.~~
254 (f)~~(g)~~ Adopt rules necessary for calculating premium
255 assistance payment levels, ~~calculating the program enrollment~~
256 ~~ceiling,~~ making premium assistance payments, monitoring access
257 and quality assurance standards, investigating and resolving
258 complaints and grievances, administering the Medikids program,
259 and approving health benefits coverage.
260
261 The agency is designated the lead state agency for Title XXI of
262 the Social Security Act for purposes of receipt of federal
263 funds, for reporting purposes, and for ensuring compliance with
264 federal and state regulations and rules.
265 Section 9. Subsection (5) of section 409.904, Florida
266 Statutes, is amended to read:
267 409.904 Optional payments for eligible persons.--The
268 agency may make payments for medical assistance and related
269 services on behalf of the following persons who are determined
270 to be eligible subject to the income, assets, and categorical
271 eligibility tests set forth in federal and state law. Payment on
272 behalf of these Medicaid eligible persons is subject to the
273 availability of moneys and any limitations established by the
274 General Appropriations Act or chapter 216.

275 (5) Subject to specific federal authorization, a
276 ~~postpartum~~ woman living in a family that has an income that is
277 at or below 185 percent of the most current federal poverty
278 level is eligible for family planning services as specified in
279 s. 409.905(3) for a period of up to 24 months following a loss
280 of Medicaid benefits ~~pregnancy for which Medicaid paid for~~
281 ~~pregnancy-related services~~.
282 Section 10. Paragraph (d) of subsection (5) of section
283 409.905, Florida Statutes, is amended to read:
284 409.905 Mandatory Medicaid services.--The agency may make
285 payments for the following services, which are required of the
286 state by Title XIX of the Social Security Act, furnished by
287 Medicaid providers to recipients who are determined to be
288 eligible on the dates on which the services were provided. Any
289 service under this section shall be provided only when medically
290 necessary and in accordance with state and federal law.
291 Mandatory services rendered by providers in mobile units to
292 Medicaid recipients may be restricted by the agency. Nothing in
293 this section shall be construed to prevent or limit the agency
294 from adjusting fees, reimbursement rates, lengths of stay,
295 number of visits, number of services, or any other adjustments
296 necessary to comply with the availability of moneys and any
297 limitations or directions provided for in the General
298 Appropriations Act or chapter 216.
299 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for
300 all covered services provided for the medical care and treatment
301 of a recipient who is admitted as an inpatient by a licensed
302 physician or dentist to a hospital licensed under part I of
303 chapter 395. However, the agency shall limit the payment for

304 inpatient hospital services for a Medicaid recipient 21 years of
305 age or older to 45 days or the number of days necessary to
306 comply with the General Appropriations Act.
307 (d) The agency shall implement a hospitalist program in
308 nonteaching ~~certain high-volume participating~~ hospitals, select
309 counties, or statewide. The program shall require hospitalists
310 to ~~authorize and~~ manage Medicaid recipients' hospital admissions
311 and lengths of stay. Individuals who are dually eligible for
312 Medicare and Medicaid are exempted from this requirement.
313 Medicaid participating physicians and other practitioners with
314 hospital admitting privileges shall coordinate and review
315 admissions of Medicaid recipients with the hospitalist. The
316 agency may competitively bid a contract for selection of a
317 single qualified organization to provide hospitalist services.
318 The agency may procure hospitalist services by individual county
319 or may combine counties in a single procurement. The qualified
320 organization shall contract with or employ board-eligible ~~board~~
321 ~~certified~~ physicians in Miami-Dade, Palm Beach, Hillsborough,
322 Pasco, and Pinellas Counties ~~who are full-time dedicated~~
323 ~~employees of the contractor and have no outside practice~~. ~~Where~~
324 ~~used, the hospitalist program shall replace the existing~~
325 ~~hospital utilization review program.~~ The agency is authorized to
326 seek federal waivers to implement this program.
327 Section 11. Paragraph (b) of subsection (1) and
328 subsections (12) and (23) of section 409.906, Florida Statutes,
329 are amended to read:
330 409.906 Optional Medicaid services.--Subject to specific
331 appropriations, the agency may make payments for services which
332 are optional to the state under Title XIX of the Social Security

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

352 (1) ADULT DENTAL SERVICES.--

353 (b) Beginning July 1, 2006 ~~January 1, 2005~~, the agency may
354 pay for full or partial dentures, the procedures required to
355 seat full or partial dentures, and the repair and reline of full
356 or partial dentures, provided by or under the direction of a
357 licensed dentist, for a recipient who is 21 years of age or
358 older.

359 (12) ~~CHILDREN'S~~ HEARING SERVICES.--The agency may pay for
360 hearing and related services, including hearing evaluations,
361 hearing aid devices, dispensing of the hearing aid, and related

362 repairs, if provided to a recipient ~~younger than 21 years of age~~
363 by a licensed hearing aid specialist, otolaryngologist,
364 otologist, audiologist, or physician.
365 (23) ~~CHILDREN'S~~ VISUAL SERVICES.--The agency may pay for
366 visual examinations, eyeglasses, and eyeglass repairs for a
367 recipient ~~younger than 21 years of age,~~ if they are prescribed
368 by a licensed physician specializing in diseases of the eye or
369 by a licensed optometrist. Eyeglasses for adult recipients shall
370 be limited to two pairs per year per recipient, except a third
371 pair may be provided after prior authorization.
372 Section 12. Paragraph (a) of subsection (9) of section
373 409.907, Florida Statutes, is amended to read:
374 409.907 Medicaid provider agreements.--The agency may make
375 payments for medical assistance and related services rendered to
376 Medicaid recipients only to an individual or entity who has a
377 provider agreement in effect with the agency, who is performing
378 services or supplying goods in accordance with federal, state,
379 and local law, and who agrees that no person shall, on the
380 grounds of handicap, race, color, or national origin, or for any
381 other reason, be subjected to discrimination under any program
382 or activity for which the provider receives payment from the
383 agency.
384 (9) Upon receipt of a completed, signed, and dated
385 application, and completion of any necessary background
386 investigation and criminal history record check, the agency must
387 either:
388 (a) Enroll the applicant as a Medicaid provider ~~no earlier~~
389 ~~than the effective date of the approval of the provider~~
390 ~~application. With respect to providers who were recently granted~~

391 ~~a change of ownership and those who primarily provide emergency~~
392 ~~medical services transportation or emergency services and care~~
393 ~~pursuant to s. 395.1041 or s. 401.45, or services provided by~~
394 ~~entities under s. 409.91255, and out-of-state providers,~~ upon
395 approval of the provider application.~~,~~ The enrollment effective
396 date shall be ~~of approval is considered to be~~ the date the
397 agency receives the provider application. Payment for any claims
398 for services provided to Medicaid recipients between the date of
399 receipt of the application and the date of approval is
400 contingent on applying any and all applicable audits and edits
401 contained in the agency's claims adjudication and payment
402 processing systems; or
403 Section 13. Paragraph (b) of subsection (2) of section
404 409.908, Florida Statutes, is amended to read:
405 409.908 Reimbursement of Medicaid providers.--Subject to
406 specific appropriations, the agency shall reimburse Medicaid
407 providers, in accordance with state and federal law, according
408 to methodologies set forth in the rules of the agency and in
409 policy manuals and handbooks incorporated by reference therein.
410 These methodologies may include fee schedules, reimbursement
411 methods based on cost reporting, negotiated fees, competitive
412 bidding pursuant to s. 287.057, and other mechanisms the agency
413 considers efficient and effective for purchasing services or
414 goods on behalf of recipients. If a provider is reimbursed based
415 on cost reporting and submits a cost report late and that cost
416 report would have been used to set a lower reimbursement rate
417 for a rate semester, then the provider's rate for that semester
418 shall be retroactively calculated using the new cost report, and
419 full payment at the recalculated rate shall be effected

420 retroactively. Medicare-granted extensions for filing cost
421 reports, if applicable, shall also apply to Medicaid cost
422 reports. Payment for Medicaid compensable services made on
423 behalf of Medicaid eligible persons is subject to the
424 availability of moneys and any limitations or directions
425 provided for in the General Appropriations Act or chapter 216.
426 Further, nothing in this section shall be construed to prevent
427 or limit the agency from adjusting fees, reimbursement rates,
428 lengths of stay, number of visits, or number of services, or
429 making any other adjustments necessary to comply with the
430 availability of moneys and any limitations or directions
431 provided for in the General Appropriations Act, provided the
432 adjustment is consistent with legislative intent.

433 (2)

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

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

449 licensed operator filed on or after September 1, 2001, are
450 equivalent to the previous owner's reimbursement rate.
451 2. The agency shall amend the long-term care reimbursement
452 plan and cost reporting system to create direct care and
453 indirect care subcomponents of the patient care component of the
454 per diem rate. These two subcomponents together shall equal the
455 patient care component of the per diem rate. Separate cost-based
456 ceilings shall be calculated for each patient care subcomponent.
457 The direct care subcomponent of the per diem rate shall be
458 limited by the cost-based class ceiling, and the indirect care
459 subcomponent may ~~shall~~ be limited by the lower of the cost-based
460 class ceiling, the target rate class ceiling, or the individual
461 provider target.
462 3. The direct care subcomponent shall include salaries and
463 benefits of direct care staff providing nursing services
464 including registered nurses, licensed practical nurses, and
465 certified nursing assistants who deliver care directly to
466 residents in the nursing home facility. This excludes nursing
467 administration, minimum data set, and care plan coordinators,
468 staff development, and staffing coordinator.
469 4. All other patient care costs shall be included in the
470 indirect care cost subcomponent of the patient care per diem
471 rate. There shall be no costs directly or indirectly allocated
472 to the direct care subcomponent from a home office or management
473 company.
474 5. On July 1 of each year, the agency shall report to the
475 Legislature direct and indirect care costs, including average
476 direct and indirect care costs per resident per facility and

477 direct care and indirect care salaries and benefits per category
478 of staff member per facility.
479 6. In order to offset the cost of general and professional
480 liability insurance, the agency shall amend the plan to allow
481 for interim rate adjustments to reflect increases in the cost of
482 general or professional liability insurance for nursing homes.
483 This provision shall be implemented to the extent existing
484 appropriations are available.
485
486 It is the intent of the Legislature that the reimbursement plan
487 achieve the goal of providing access to health care for nursing
488 home residents who require large amounts of care while
489 encouraging diversion services as an alternative to nursing home
490 care for residents who can be served within the community. The
491 agency shall base the establishment of any maximum rate of
492 payment, whether overall or component, on the available moneys
493 as provided for in the General Appropriations Act. The agency
494 may base the maximum rate of payment on the results of
495 scientifically valid analysis and conclusions derived from
496 objective statistical data pertinent to the particular maximum
497 rate of payment.
498 Section 14. Paragraph (c) of subsection (1) of section
499 409.9081, Florida Statutes, is amended to read:
500 409.9081 Copayments.--
501 (1) The agency shall require, subject to federal
502 regulations and limitations, each Medicaid recipient to pay at
503 the time of service a nominal copayment for the following
504 Medicaid services:

505 (c) Hospital emergency department visits for nonemergency
506 care: 5 percent of up to the first $300 of the Medicaid payment
507 for emergency room services, not to exceed $15 ~~for each~~
508 ~~emergency department visit~~.
509 Section 15. Subsections (2), (3), and (4) of section
510 409.911, Florida Statutes, are amended to read:
511 409.911 Disproportionate share program.--Subject to
512 specific allocations established within the General
513 Appropriations Act and any limitations established pursuant to
514 chapter 216, the agency shall distribute, pursuant to this
515 section, moneys to hospitals providing a disproportionate share
516 of Medicaid or charity care services by making quarterly
517 Medicaid payments as required. Notwithstanding the provisions of
518 s. 409.915, counties are exempt from contributing toward the
519 cost of this special reimbursement for hospitals serving a
520 disproportionate share of low-income patients.
521 (2) The Agency for Health Care Administration shall use
522 the following actual audited data to determine the Medicaid days
523 and charity care to be used in calculating the disproportionate
524 share payment:
525 (a) The average of the ~~1998, 1999, and~~ 2000, 2001, and
526 2002 audited disproportionate share data to determine each
527 hospital's Medicaid days and charity care for the 2006-2007
528 ~~2004-2005~~ state fiscal year ~~and the average of the 1999, 2000,~~
529 ~~and 2001 audited disproportionate share data to determine the~~
530 ~~Medicaid days and charity care for the 2005-2006 state fiscal~~
531 ~~year~~.
532 (b) If the Agency for Health Care Administration does not
533 have the prescribed 3 years of audited disproportionate share

534 data as noted in paragraph (a) for a hospital, the agency shall
535 use the average of the years of the audited disproportionate
536 share data as noted in paragraph (a) which is available.
537 (c) In accordance with s. 1923(b) of the Social Security
538 Act, a hospital with a Medicaid inpatient utilization rate
539 greater than one standard deviation above the statewide mean or
540 a hospital with a low-income utilization rate of 25 percent or
541 greater shall qualify for reimbursement.
542 (3) Hospitals that qualify for a disproportionate share
543 payment solely under paragraph (2)(c) shall have their payment
544 calculated in accordance with the following formulas:
545
546 DSHP = (HMD/TMSD) x $1 million
547
548 Where:
549 DSHP = disproportionate share hospital payment.
550 HMD = hospital Medicaid days.
551 TSD = total state Medicaid days.
552
553 Any funds not allocated to hospitals qualifying under this
554 section shall be redistributed to the non-state government owned
555 or operated hospitals with greater than 3,100 ~~3,300~~ Medicaid
556 days.
557 (4) The following formulas shall be used to pay
558 disproportionate share dollars to public hospitals:
559 (a) For state mental health hospitals:
560
561 DSHP = (HMD/TMDMH) x TAAMH
562

563 shall be the difference between the federal cap for Institutions
564 for Mental Diseases and the amounts paid under the mental health
565 disproportionate share program.
566
567 Where:
568 DSHP = disproportionate share hospital payment.
569 HMD = hospital Medicaid days.
570 TMDHH = total Medicaid days for state mental health
571 hospitals.
572 TAAMH = total amount available for mental health hospitals.
573 (b) For non-state government owned or operated hospitals
574 with 3,100 ~~3,300~~ or more Medicaid days:
575
576 DSHP = [(.82 x HCCD/TCCD) + (.18 x HMD/TMD)]
577 x TAAPH
578 TAAPH = TAA - TAAMH
579
580 Where:
581 TAA = total available appropriation.
582 TAAPH = total amount available for public hospitals.
583 DSHP = disproportionate share hospital payments.
584 HMD = hospital Medicaid days.
585 TMD = total state Medicaid days for public hospitals.
586 HCCD = hospital charity care dollars.
587 TCCD = total state charity care dollars for public non-
588 state hospitals.
589
590 ~~1. For the 2005-2006 state fiscal year only, the DSHP for~~
591 ~~the public nonstate hospitals shall be computed using a weighted~~

592 ~~average of the disproportionate share payments for the 2004-2005~~
593 ~~state fiscal year which uses an average of the 1998, 1999, and~~
594 ~~2000 audited disproportionate share data and the~~
595 ~~disproportionate share payments for the 2005-2006 state fiscal~~
596 ~~year as computed using the formula above and using the average~~
597 ~~of the 1999, 2000, and 2001 audited disproportionate share data.~~
598 ~~The final DSHP for the public nonstate hospitals shall be~~
599 ~~computed as an average using the calculated payments for the~~
600 ~~2005-2006 state fiscal year weighted at 65 percent and the~~
601 ~~disproportionate share payments for the 2004-2005 state fiscal~~
602 ~~year weighted at 35 percent.~~
603 ~~2.~~ The TAAPH shall be reduced by $6,365,257 before
604 computing the DSHP for each public hospital. The $6,365,257
605 shall be distributed equally between the public hospitals that
606 are also designated statutory teaching hospitals.
607 (c) For non-state government owned or operated hospitals
608 with less than 3,100 ~~3,300~~ Medicaid days, a total of $750,000
609 shall be distributed equally among these hospitals.
610 Section 16. Section 409.9113, Florida Statutes, is amended
611 to read:
612 409.9113 Disproportionate share program for teaching
613 hospitals.--In addition to the payments made under ss. 409.911
614 and 409.9112, the Agency for Health Care Administration shall
615 make disproportionate share payments to statutorily defined
616 teaching hospitals for their increased costs associated with
617 medical education programs and for tertiary health care services
618 provided to the indigent. This system of payments shall conform
619 with federal requirements and shall distribute funds in each
620 fiscal year for which an appropriation is made by making

621 quarterly Medicaid payments. Notwithstanding s. 409.915,
622 counties are exempt from contributing toward the cost of this
623 special reimbursement for hospitals serving a disproportionate
624 share of low-income patients. For the state fiscal year 2006-
625 2007 ~~2005-2006~~, the agency shall ~~not~~ distribute the moneys
626 provided in the General Appropriations Act to statutorily
627 defined teaching hospitals and family practice teaching
628 hospitals under the teaching hospital disproportionate share
629 program. The funds provided for statutorily defined teaching
630 hospitals shall be distributed in the same proportion as the
631 state fiscal year 2003-2004 teaching hospital disproportionate
632 share funds were distributed. The funds provided for family
633 practice teaching hospitals shall be distributed equally among
634 family practice teaching hospitals.

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

646 (a) The number of nationally accredited graduate medical
647 education programs offered by the hospital, including programs
648 accredited by the Accreditation Council for Graduate Medical
649 Education and the combined Internal Medicine and Pediatrics

650 programs acceptable to both the American Board of Internal
651 Medicine and the American Board of Pediatrics at the beginning
652 of the state fiscal year preceding the date on which the
653 allocation fraction is calculated. The numerical value of this
654 factor is the fraction that the hospital represents of the total
655 number of programs, where the total is computed for all state
656 statutory teaching hospitals.
657 (b) The number of full-time equivalent trainees in the
658 hospital, which comprises two components:
659 1. The number of trainees enrolled in nationally
660 accredited graduate medical education programs, as defined in
661 paragraph (a). Full-time equivalents are computed using the
662 fraction of the year during which each trainee is primarily
663 assigned to the given institution, over the state fiscal year
664 preceding the date on which the allocation fraction is
665 calculated. The numerical value of this factor is the fraction
666 that the hospital represents of the total number of full-time
667 equivalent trainees enrolled in accredited graduate programs,
668 where the total is computed for all state statutory teaching
669 hospitals.
670 2. The number of medical students enrolled in accredited
671 colleges of medicine and engaged in clinical activities,
672 including required clinical clerkships and clinical electives.
673 Full-time equivalents are computed using the fraction of the
674 year during which each trainee is primarily assigned to the
675 given institution, over the course of the state fiscal year
676 preceding the date on which the allocation fraction is
677 calculated. The numerical value of this factor is the fraction
678 that the given hospital represents of the total number of full-

679 time equivalent students enrolled in accredited colleges of
680 medicine, where the total is computed for all state statutory
681 teaching hospitals.
682
683 The primary factor for full-time equivalent trainees is computed
684 as the sum of these two components, divided by two.
685 (c) A service index that comprises three components:
686 1. The Agency for Health Care Administration Service
687 Index, computed by applying the standard Service Inventory
688 Scores established by the Agency for Health Care Administration
689 to services offered by the given hospital, as reported on
690 Worksheet A-2 for the last fiscal year reported to the agency
691 before the date on which the allocation fraction is calculated.
692 The numerical value of this factor is the fraction that the
693 given hospital represents of the total Agency for Health Care
694 Administration Service Index values, where the total is computed
695 for all state statutory teaching hospitals.
696 2. A volume-weighted service index, computed by applying
697 the standard Service Inventory Scores established by the Agency
698 for Health Care Administration to the volume of each service,
699 expressed in terms of the standard units of measure reported on
700 Worksheet A-2 for the last fiscal year reported to the agency
701 before the date on which the allocation factor is calculated.
702 The numerical value of this factor is the fraction that the
703 given hospital represents of the total volume-weighted service
704 index values, where the total is computed for all state
705 statutory teaching hospitals.
706 3. Total Medicaid payments to each hospital for direct
707 inpatient and outpatient services during the fiscal year

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

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

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

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

Section 17. 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.

736 (1) If federal funds are available for disproportionate
737 share programs in addition to those otherwise provided by law,
738 there shall be created a primary care disproportionate share
739 program.
740 (2) The following formula shall be used by the agency to
741 calculate the total amount earned for hospitals that participate
742 in the primary care disproportionate share program:
743
744 TAE = HDSP/THDSP
745
746 Where:
747 TAE = total amount earned by a hospital participating in
748 the primary care disproportionate share program.
749 HDSP = the prior state fiscal year primary care
750 disproportionate share payment to the individual hospital.
751 THDSP = the prior state fiscal year total primary care
752 disproportionate share payments to all hospitals.
753 (3) The total additional payment for hospitals that
754 participate in the primary care disproportionate share program
755 shall be calculated by the agency as follows:
756
757 TAP = TAE x TA
758
759 Where:
760 TAP = total additional payment for a primary care hospital.
761 TAE = total amount earned by a primary care hospital.
762 TA = total appropriation for the primary care
763 disproportionate share program.

764 (4) In the establishment and funding of this program, the
765 agency shall use the following criteria in addition to those
766 specified in s. 409.911, payments may not be made to a hospital
767 unless the hospital agrees to:
768 (a) Cooperate with a Medicaid prepaid health plan, if one
769 exists in the community.
770 (b) Ensure the availability of primary and specialty care
771 physicians to Medicaid recipients who are not enrolled in a
772 prepaid capitated arrangement and who are in need of access to
773 such physicians.
774 (c) Coordinate and provide primary care services free of
775 charge, except copayments, to all persons with incomes up to 100
776 percent of the federal poverty level who are not otherwise
777 covered by Medicaid or another program administered by a
778 governmental entity, and to provide such services based on a
779 sliding fee scale to all persons with incomes up to 200 percent
780 of the federal poverty level who are not otherwise covered by
781 Medicaid or another program administered by a governmental
782 entity, except that eligibility may be limited to persons who
783 reside within a more limited area, as agreed to by the agency
784 and the hospital.
785 (d) Contract with any federally qualified health center,
786 if one exists within the agreed geopolitical boundaries,
787 concerning the provision of primary care services, in order to
788 guarantee delivery of services in a nonduplicative fashion, and
789 to provide for referral arrangements, privileges, and
790 admissions, as appropriate. The hospital shall agree to provide
791 at an onsite or offsite facility primary care services within 24
792 hours to which all Medicaid recipients and persons eligible

793 under this paragraph who do not require emergency room services
794 are referred during normal daylight hours.

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

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

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

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

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

822 (j) Work with the local health council to develop a plan
823 for promoting access to affordable health care services for all
824 persons who reside within the area, including, but not limited
825 to, public health services, primary care services, inpatient
826 services, and affordable health insurance generally.
827
828 Any hospital that fails to comply with any of the provisions of
829 this subsection, or any other contractual condition, may not
830 receive payments under this section until full compliance is
831 achieved.
832 Section 18. Paragraph (a) of subsection (39) and
833 subsection (44) of section 409.912, Florida Statutes, are
834 amended to read:
835 409.912 Cost-effective purchasing of health care.--The
836 agency shall purchase goods and services for Medicaid recipients
837 in the most cost-effective manner consistent with the delivery
838 of quality medical care. To ensure that medical services are
839 effectively utilized, the agency may, in any case, require a
840 confirmation or second physician's opinion of the correct
841 diagnosis for purposes of authorizing future services under the
842 Medicaid program. This section does not restrict access to
843 emergency services or poststabilization care services as defined
844 in 42 C.F.R. part 438.114. Such confirmation or second opinion
845 shall be rendered in a manner approved by the agency. The agency
846 shall maximize the use of prepaid per capita and prepaid
847 aggregate fixed-sum basis services when appropriate and other
848 alternative service delivery and reimbursement methodologies,
849 including competitive bidding pursuant to s. 287.057, designed
850 to facilitate the cost-effective purchase of a case-managed

851 continuum of care. The agency shall also require providers to
852 minimize the exposure of recipients to the need for acute
853 inpatient, custodial, and other institutional care and the
854 inappropriate or unnecessary use of high-cost services. The
855 agency shall contract with a vendor to monitor and evaluate the
856 clinical practice patterns of providers in order to identify
857 trends that are outside the normal practice patterns of a
858 provider's professional peers or the national guidelines of a
859 provider's professional association. The vendor must be able to
860 provide information and counseling to a provider whose practice
861 patterns are outside the norms, in consultation with the agency,
862 to improve patient care and reduce inappropriate utilization.
863 The agency may mandate prior authorization, drug therapy
864 management, or disease management participation for certain
865 populations of Medicaid beneficiaries, certain drug classes, or
866 particular drugs to prevent fraud, abuse, overuse, and possible
867 dangerous drug interactions. The Pharmaceutical and Therapeutics
868 Committee shall make recommendations to the agency on drugs for
869 which prior authorization is required. The agency shall inform
870 the Pharmaceutical and Therapeutics Committee of its decisions
871 regarding drugs subject to prior authorization. The agency is
872 authorized to limit the entities it contracts with or enrolls as
873 Medicaid providers by developing a provider network through
874 provider credentialing. The agency may competitively bid single-
875 source-provider contracts if procurement of goods or services
876 results in demonstrated cost savings to the state without
877 limiting access to care. The agency may limit its network based
878 on the assessment of beneficiary access to care, provider
879 availability, provider quality standards, time and distance

880 standards for access to care, the cultural competence of the
881 provider network, demographic characteristics of Medicaid
882 beneficiaries, practice and provider-to-beneficiary standards,
883 appointment wait times, beneficiary use of services, provider
884 turnover, provider profiling, provider licensure history,
885 previous program integrity investigations and findings, peer
886 review, provider Medicaid policy and billing compliance records,
887 clinical and medical record audits, and other factors. Providers
888 shall not be entitled to enrollment in the Medicaid provider
889 network. The agency shall determine instances in which allowing
890 Medicaid beneficiaries to purchase durable medical equipment and
891 other goods is less expensive to the Medicaid program than long-
892 term rental of the equipment or goods. The agency may establish
893 rules to facilitate purchases in lieu of long-term rentals in
894 order to protect against fraud and abuse in the Medicaid program
895 as defined in s. 409.913. The agency may seek federal waivers
896 necessary to administer these policies.
897 (39)(a) The agency shall implement a Medicaid prescribed-
898 drug spending-control program that includes the following
899 components:
900 1. A Medicaid preferred drug list, which shall be a
901 listing of cost-effective therapeutic options recommended by the
902 Medicaid Pharmacy and Therapeutics Committee established
903 pursuant to s. 409.91195 and adopted by the agency for each
904 therapeutic class on the preferred drug list. At the discretion
905 of the committee, and when feasible, the preferred drug list
906 should include at least two products in a therapeutic class. The
907 agency may post the preferred drug list and updates to the
908 preferred drug list on an Internet website without following the

909 rulemaking procedures of chapter 120. Antiretroviral agents are
910 excluded from the preferred drug list. The agency shall also
911 limit the amount of a prescribed drug dispensed to no more than
912 a 34-day supply unless the drug products' smallest marketed
913 package is greater than a 34-day supply, or the drug is
914 determined by the agency to be a maintenance drug in which case
915 a 100-day maximum supply may be authorized. The agency is
916 authorized to seek any federal waivers necessary to implement
917 these cost-control programs and to continue participation in the
918 federal Medicaid rebate program, or alternatively to negotiate
919 state-only manufacturer rebates. The agency may adopt rules to
920 implement this subparagraph. The agency shall continue to
921 provide unlimited contraceptive drugs and items. The agency must
922 establish procedures to ensure that:
923 a. There will be a response to a request for prior
924 consultation by telephone or other telecommunication device
925 within 24 hours after receipt of a request for prior
926 consultation; and
927 b. A 72-hour supply of the drug prescribed will be
928 provided in an emergency or when the agency does not provide a
929 response within 24 hours as required by sub-subparagraph a.
930 2. Reimbursement to pharmacies for Medicaid prescribed
931 drugs shall be set at the lesser of: the average wholesale price
932 (AWP) minus 15.4 percent, the wholesaler acquisition cost (WAC)
933 plus 5.75 percent, the federal upper limit (FUL), the state
934 maximum allowable cost (SMAC), or the usual and customary (UAC)
935 charge billed by the provider.
936 3. The agency shall develop and implement a process for
937 managing the drug therapies of Medicaid recipients who are using

938 significant numbers of prescribed drugs each month. The
939 management process may include, but is not limited to,
940 comprehensive, physician-directed medical-record reviews, claims
941 analyses, and case evaluations to determine the medical
942 necessity and appropriateness of a patient's treatment plan and
943 drug therapies. The agency may contract with a private
944 organization to provide drug-program-management services. The
945 Medicaid drug benefit management program shall include
946 initiatives to manage drug therapies for HIV/AIDS patients,
947 patients using 20 or more unique prescriptions in a 180-day
948 period, and the top 1,000 patients in annual spending. The
949 agency shall enroll any Medicaid recipient in the drug benefit
950 management program if he or she meets the specifications of this
951 provision and is not enrolled in a Medicaid health maintenance
952 organization.
953 4. The agency may limit the size of its pharmacy network
954 based on need, competitive bidding, price negotiations,
955 credentialing, or similar criteria. The agency shall give
956 special consideration to rural areas in determining the size and
957 location of pharmacies included in the Medicaid pharmacy
958 network. A pharmacy credentialing process may include criteria
959 such as a pharmacy's full-service status, location, size,
960 patient educational programs, patient consultation, disease
961 management services, and other characteristics. The agency may
962 impose a moratorium on Medicaid pharmacy enrollment when it is
963 determined that it has a sufficient number of Medicaid-
964 participating providers. The agency must allow dispensing
965 practitioners to participate as a part of the Medicaid pharmacy
966 network regardless of the practitioner's proximity to any other

967 entity that is dispensing prescription drugs under the Medicaid
968 program. A dispensing practitioner must meet all credentialing
969 requirements applicable to his or her practice, as determined by
970 the agency.
971 5. The agency shall develop and implement a program that
972 requires Medicaid practitioners who prescribe drugs to use a
973 counterfeit-proof prescription pad for Medicaid prescriptions.
974 The agency shall require the use of standardized counterfeit-
975 proof prescription pads by Medicaid-participating prescribers or
976 prescribers who write prescriptions for Medicaid recipients. The
977 agency may implement the program in targeted geographic areas or
978 statewide.
979 6. The agency may enter into arrangements that require
980 manufacturers of generic drugs prescribed to Medicaid recipients
981 to provide rebates of at least 15.1 percent of the average
982 manufacturer price for the manufacturer's generic products.
983 These arrangements shall require that if a generic-drug
984 manufacturer pays federal rebates for Medicaid-reimbursed drugs
985 at a level below 15.1 percent, the manufacturer must provide a
986 supplemental rebate to the state in an amount necessary to
987 achieve a 15.1-percent rebate level.
988 7. The agency may establish a preferred drug list as
989 described in this subsection, and, pursuant to the establishment
990 of such preferred drug list, it is authorized to negotiate
991 supplemental rebates from manufacturers that are in addition to
992 those required by Title XIX of the Social Security Act and at no
993 less than 14 percent of the average manufacturer price as
994 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
995 the federal or supplemental rebate, or both, equals or exceeds

996 29 percent. There is no upper limit on the supplemental rebates
997 the agency may negotiate. The agency may determine that specific
998 products, brand-name or generic, are competitive at lower rebate
999 percentages. Agreement to pay the minimum supplemental rebate
1000 percentage will guarantee a manufacturer that the Medicaid
1001 Pharmaceutical and Therapeutics Committee will consider a
1002 product for inclusion on the preferred drug list. However, a
1003 pharmaceutical manufacturer is not guaranteed placement on the
1004 preferred drug list by simply paying the minimum supplemental
1005 rebate. Agency decisions will be made on the clinical efficacy
1006 of a drug and recommendations of the Medicaid Pharmaceutical and
1007 Therapeutics Committee, as well as the price of competing
1008 products minus federal and state rebates. The agency is
1009 authorized to contract with an outside agency or contractor to
1010 conduct negotiations for supplemental rebates. For the purposes
1011 of this section, the term "supplemental rebates" means cash
1012 rebates. Effective July 1, 2004, value-added programs as a
1013 substitution for supplemental rebates are prohibited. The agency
1014 is authorized to seek any federal waivers to implement this
1015 initiative.
1016 8. The Agency for Health Care Administration shall expand
1017 home delivery of pharmacy products. To assist Medicaid patients
1018 in securing their prescriptions and reduce program costs, the
1019 agency shall expand its current mail-order-pharmacy diabetes-
1020 supply program to include all generic and brand-name drugs used
1021 by Medicaid patients with diabetes. Medicaid recipients in the
1022 current program may obtain nondiabetes drugs on a voluntary
1023 basis. This initiative is limited to the geographic area covered

1024 by the current contract. The agency may seek and implement any
1025 federal waivers necessary to implement this subparagraph.
1026 9. The agency shall limit to one dose per month any drug
1027 prescribed to treat erectile dysfunction.
1028 10.a. The agency may implement a Medicaid behavioral drug
1029 management system. The agency may contract with a vendor that
1030 has experience in operating behavioral drug management systems
1031 to implement this program. The agency is authorized to seek
1032 federal waivers to implement this program.
1033 b. The agency, in conjunction with the Department of
1034 Children and Family Services, may implement the Medicaid
1035 behavioral drug management system that is designed to improve
1036 the quality of care and behavioral health prescribing practices
1037 based on best practice guidelines, improve patient adherence to
1038 medication plans, reduce clinical risk, and lower prescribed
1039 drug costs and the rate of inappropriate spending on Medicaid
1040 behavioral drugs. The program may include the following
1041 elements:
1042 (I) Provide for the development and adoption of best
1043 practice guidelines for behavioral health-related drugs such as
1044 antipsychotics, antidepressants, and medications for treating
1045 bipolar disorders and other behavioral conditions; translate
1046 them into practice; review behavioral health prescribers and
1047 compare their prescribing patterns to a number of indicators
1048 that are based on national standards; and determine deviations
1049 from best practice guidelines.
1050 (II) Implement processes for providing feedback to and
1051 educating prescribers using best practice educational materials
1052 and peer-to-peer consultation.

1053 (III) Assess Medicaid beneficiaries who are outliers in
1054 their use of behavioral health drugs with regard to the numbers
1055 and types of drugs taken, drug dosages, combination drug
1056 therapies, and other indicators of improper use of behavioral
1057 health drugs.
1058 (IV) Alert prescribers to patients who fail to refill
1059 prescriptions in a timely fashion, are prescribed multiple same-
1060 class behavioral health drugs, and may have other potential
1061 medication problems.
1062 (V) Track spending trends for behavioral health drugs and
1063 deviation from best practice guidelines.
1064 (VI) Use educational and technological approaches to
1065 promote best practices, educate consumers, and train prescribers
1066 in the use of practice guidelines.
1067 (VII) Disseminate electronic and published materials.
1068 (VIII) Hold statewide and regional conferences.
1069 (IX) Implement a disease management program with a model
1070 quality-based medication component for severely mentally ill
1071 individuals and emotionally disturbed children who are high
1072 users of care.
1073 11.a. The agency shall implement a Medicaid prescription
1074 drug management system. The agency may contract with a vendor
1075 that has experience in operating prescription drug management
1076 systems in order to implement this system. Any management system
1077 that is implemented in accordance with this subparagraph must
1078 rely on cooperation between physicians and pharmacists to
1079 determine appropriate practice patterns and clinical guidelines
1080 to improve the prescribing, dispensing, and use of drugs in the

1081 Medicaid program. The agency may seek federal waivers to
1082 implement this program.
1083 b. The drug management system must be designed to improve
1084 the quality of care and prescribing practices based on best
1085 practice guidelines, improve patient adherence to medication
1086 plans, reduce clinical risk, and lower prescribed drug costs and
1087 the rate of inappropriate spending on Medicaid prescription
1088 drugs. The program must:
1089 (I) Provide for the development and adoption of best
1090 practice guidelines for the prescribing and use of drugs in the
1091 Medicaid program, including translating best practice guidelines
1092 into practice; reviewing prescriber patterns and comparing them
1093 to indicators that are based on national standards and practice
1094 patterns of clinical peers in their community, statewide, and
1095 nationally; and determine deviations from best practice
1096 guidelines.
1097 (II) Implement processes for providing feedback to and
1098 educating prescribers using best practice educational materials
1099 and peer-to-peer consultation.
1100 (III) Assess Medicaid recipients who are outliers in their
1101 use of a single or multiple prescription drugs with regard to
1102 the numbers and types of drugs taken, drug dosages, combination
1103 drug therapies, and other indicators of improper use of
1104 prescription drugs.
1105 (IV) Alert prescribers to patients who fail to refill
1106 prescriptions in a timely fashion, are prescribed multiple drugs
1107 that may be redundant or contraindicated, or may have other
1108 potential medication problems.

1109 (V) Track spending trends for prescription drugs and
1110 deviation from best practice guidelines.
1111 (VI) Use educational and technological approaches to
1112 promote best practices, educate consumers, and train prescribers
1113 in the use of practice guidelines.
1114 (VII) Disseminate electronic and published materials.
1115 (VIII) Hold statewide and regional conferences.
1116 (IX) Implement disease management programs in cooperation
1117 with physicians and pharmacists, along with a model quality-
1118 based medication component for individuals having chronic
1119 medical conditions.
1120 12. The agency is authorized to contract for drug rebate
1121 administration, including, but not limited to, calculating
1122 rebate amounts, invoicing manufacturers, negotiating disputes
1123 with manufacturers, and maintaining a database of rebate
1124 collections.
1125 13. The agency may specify the preferred daily dosing form
1126 or strength for the purpose of promoting best practices with
1127 regard to the prescribing of certain drugs as specified in the
1128 General Appropriations Act and ensuring cost-effective
1129 prescribing practices.
1130 14. The agency may require prior authorization for
1131 Medicaid-covered prescribed drugs. The agency may, but is not
1132 required to, prior-authorize the use of a product:
1133 a. For an indication not approved in labeling;
1134 b. To comply with certain clinical guidelines; or
1135 c. If the product has the potential for overuse, misuse,
1136 or abuse.
1137

1138 The agency may require the prescribing professional to provide
1139 information about the rationale and supporting medical evidence
1140 for the use of a drug. The agency may post prior authorization
1141 criteria and protocol and updates to the list of drugs that are
1142 subject to prior authorization on an Internet website without
1143 amending its rule or engaging in additional rulemaking.
1144 15. The agency, in conjunction with the Pharmaceutical and
1145 Therapeutics Committee, may require age-related prior
1146 authorizations for certain prescribed drugs. The agency may
1147 preauthorize the use of a drug for a recipient who may not meet
1148 the age requirement or may exceed the length of therapy for use
1149 of this product as recommended by the manufacturer and approved
1150 by the Food and Drug Administration. Prior authorization may
1151 require the prescribing professional to provide information
1152 about the rationale and supporting medical evidence for the use
1153 of a drug.
1154 16. The agency shall implement a step-therapy prior
1155 authorization approval process for medications excluded from the
1156 preferred drug list. Medications listed on the preferred drug
1157 list must be used within the previous 12 months prior to the
1158 alternative medications that are not listed. The step-therapy
1159 prior authorization may require the prescriber to use the
1160 medications of a similar drug class or for a similar medical
1161 indication unless contraindicated in the Food and Drug
1162 Administration labeling. The trial period between the specified
1163 steps may vary according to the medical indication. The step-
1164 therapy approval process shall be developed in accordance with
1165 the committee as stated in s. 409.91195(7) and (8). A drug
1166 product may be approved without meeting the step-therapy prior

1167 authorization criteria if the prescribing physician provides the
1168 agency with additional written medical or clinical documentation
1169 that the product is medically necessary because:

1170 a. There is not a drug on the preferred drug list to treat
1171 the disease or medical condition which is an acceptable clinical
1172 alternative;

1173 b. The alternatives have been ineffective in the treatment
1174 of the beneficiary's disease; or

1175 c. Based on historic evidence and known characteristics of
1176 the patient and the drug, the drug is likely to be ineffective,
1177 or the number of doses have been ineffective.

1178

1179 The agency shall work with the physician to determine the best
1180 alternative for the patient. The agency may adopt rules waiving
1181 the requirements for written clinical documentation for specific
1182 drugs in limited clinical situations.

1183 17. The agency shall implement a return and reuse program
1184 for drugs dispensed by pharmacies to institutional recipients,
1185 which includes payment of a $5 restocking fee for the
1186 implementation and operation of the program. The return and
1187 reuse program shall be implemented electronically and in a
1188 manner that promotes efficiency. The program must permit a
1189 pharmacy to exclude drugs from the program if it is not
1190 practical or cost-effective for the drug to be included and must
1191 provide for the return to inventory of drugs that cannot be
1192 credited or returned in a cost-effective manner. The agency
1193 shall determine if the program has reduced the amount of
1194 Medicaid prescription drugs which are destroyed on an annual
1195 basis and if there are additional ways to ensure more

1196 prescription drugs are not destroyed which could safely be
1197 reused. The agency's conclusion and recommendations shall be
1198 reported to the Legislature by December 1, 2005.
1199 (44) The Agency for Health Care Administration shall
1200 ensure that any Medicaid managed care plan as defined in s.
1201 409.9122(2)(f)~~(h)~~, whether paid on a capitated basis or a shared
1202 savings basis, is cost-effective. For purposes of this
1203 subsection, the term "cost-effective" means that a network's
1204 per-member, per-month costs to the state, including, but not
1205 limited to, fee-for-service costs, administrative costs, and
1206 case-management fees, if any, must be no greater than the
1207 state's costs associated with contracts for Medicaid services
1208 established under subsection (3), which may ~~shall~~ be ~~actuarially~~
1209 adjusted for health status ~~case mix, model, and service area~~.
1210 The agency shall conduct actuarially sound adjustments for
1211 health status ~~audits adjusted for case mix and model~~ in order to
1212 ensure such cost-effectiveness and shall publish the ~~audit~~
1213 results on its Internet website and submit the ~~audit~~ results
1214 annually to the Governor, the President of the Senate, and the
1215 Speaker of the House of Representatives no later than December
1216 31 of each year. Contracts established pursuant to this
1217 subsection which are not cost-effective may not be renewed.
1218 Section 19. Paragraphs (f) and (k) of subsection (2) of
1219 section 409.9122, Florida Statutes, are amended to read:
1220 409.9122 Mandatory Medicaid managed care enrollment;
1221 programs and procedures.--
1222 (2)
1223 (f) When a Medicaid recipient does not choose a managed
1224 care plan or MediPass provider, the agency shall assign the

1225 Medicaid recipient to a managed care plan or MediPass provider.
1226 Medicaid recipients who are subject to mandatory assignment but
1227 who fail to make a choice shall be assigned to managed care
1228 plans until an enrollment of 35 ~~40~~ percent in MediPass and 65 ~~60~~
1229 percent in managed care plans, of all those eligible to choose
1230 managed care, is achieved. Once this enrollment is achieved, the
1231 assignments shall be divided in order to maintain an enrollment
1232 in MediPass and managed care plans which is in a 35 ~~40~~ percent
1233 and 65 ~~60~~ percent proportion, respectively. Thereafter,
1234 assignment of Medicaid recipients who fail to make a choice
1235 shall be based proportionally on the preferences of recipients
1236 who have made a choice in the previous period. Such proportions
1237 shall be revised at least quarterly to reflect an update of the
1238 preferences of Medicaid recipients. The agency shall
1239 disproportionately assign Medicaid-eligible recipients who are
1240 required to but have failed to make a choice of managed care
1241 plan or MediPass, including children, and who are to be assigned
1242 to the MediPass program to children's networks as described in
1243 s. 409.912(4)(g), Children's Medical Services Network as defined
1244 in s. 391.021, exclusive provider organizations, provider
1245 service networks, minority physician networks, and pediatric
1246 emergency department diversion programs authorized by this
1247 chapter or the General Appropriations Act, in such manner as the
1248 agency deems appropriate, until the agency has determined that
1249 the networks and programs have sufficient numbers to be
1250 economically operated. For purposes of this paragraph, when
1251 referring to assignment, the term "managed care plans" includes
1252 health maintenance organizations, exclusive provider
1253 organizations, provider service networks, minority physician

1254 networks, Children's Medical Services Network, and pediatric
1255 emergency department diversion programs authorized by this
1256 chapter or the General Appropriations Act. When making
1257 assignments, the agency shall take into account the following
1258 criteria:

1259 1. A managed care plan has sufficient network capacity to
1260 meet the need of members.

1261 2. The managed care plan or MediPass has previously
1262 enrolled the recipient as a member, or one of the managed care
1263 plan's primary care providers or MediPass providers has
1264 previously provided health care to the recipient.

1265 3. The agency has knowledge that the member has previously
1266 expressed a preference for a particular managed care plan or
1267 MediPass provider as indicated by Medicaid fee-for-service
1268 claims data, but has failed to make a choice.

1269 4. The managed care plan's or MediPass primary care
1270 providers are geographically accessible to the recipient's
1271 residence.

1272 (k) When a Medicaid recipient does not choose a managed
1273 care plan or MediPass provider, the agency shall assign the
1274 Medicaid recipient to a managed care plan, except in those
1275 counties in which there are fewer than two managed care plans
1276 accepting Medicaid enrollees, in which case assignment shall be
1277 to a managed care plan or a MediPass provider. Medicaid
1278 recipients in counties with fewer than two managed care plans
1279 accepting Medicaid enrollees who are subject to mandatory
1280 assignment but who fail to make a choice shall be assigned to
1281 managed care plans until an enrollment of 35 ~~40~~ percent in
1282 MediPass and 65 ~~60~~ percent in managed care plans, of all those

1283 eligible to choose managed care, is achieved. Once that
1284 enrollment is achieved, the assignments shall be divided in
1285 order to maintain an enrollment in MediPass and managed care
1286 plans which is in a 35 ~~40~~ percent and 65 ~~60~~ percent proportion,
1287 respectively. In service areas 1 and 6 of the Agency for Health
1288 Care Administration where the agency is contracting for the
1289 provision of comprehensive behavioral health services through a
1290 capitated prepaid arrangement, recipients who fail to make a
1291 choice shall be assigned equally to MediPass or a managed care
1292 plan. For purposes of this paragraph, when referring to
1293 assignment, the term "managed care plans" includes exclusive
1294 provider organizations, provider service networks, Children's
1295 Medical Services Network, minority physician networks, and
1296 pediatric emergency department diversion programs authorized by
1297 this chapter or the General Appropriations Act. When making
1298 assignments, the agency shall take into account the following
1299 criteria:
1300 1. A managed care plan has sufficient network capacity to
1301 meet the need of members.
1302 2. The managed care plan or MediPass has previously
1303 enrolled the recipient as a member, or one of the managed care
1304 plan's primary care providers or MediPass providers has
1305 previously provided health care to the recipient.
1306 3. The agency has knowledge that the member has previously
1307 expressed a preference for a particular managed care plan or
1308 MediPass provider as indicated by Medicaid fee-for-service
1309 claims data, but has failed to make a choice.

1310 4. The managed care plan's or MediPass primary care
1311 providers are geographically accessible to the recipient's
1312 residence.
1313 5. The agency has authority to make mandatory assignments
1314 based on quality of service and performance of managed care
1315 plans.
1316 Section 20. Section 409.9301, Florida Statutes, is created
1317 to read:
1318 409.9301 Pharmaceutical expense assistance.--
1319 (1) PROGRAM ESTABLISHED.--A program is established in the
1320 Agency for Health Care Administration to provide pharmaceutical
1321 expense assistance to individuals diagnosed with cancer or
1322 individuals who have received organ transplants who were
1323 medically needy recipients prior to January 1, 2006.
1324 (2) ELIGIBILITY.--Eligibility for the program is limited
1325 to an individual who:
1326 (a) Is a resident of this state;
1327 (b) Was a Medicaid recipient under the Florida Medicaid
1328 medically needy program prior to January 1, 2006;
1329 (c) Is eligible for Medicare;
1330 (d) Is a cancer patient or an organ transplant recipient;
1331 and
1332 (e) Requests to be enrolled in the program.
1333 (3) BENEFITS.--Subject to an appropriation in the General
1334 Appropriations Act and the availability of funds, the Agency for
1335 Health Care Administration shall pay, using Medicaid payment
1336 policies, the Medicare Part-B prescription drug coinsurance and
1337 deductibles for Medicare Part-B medications that treat eligible
1338 cancer and organ transplant patients.

1339 (4) ADMINISTRATION.--The pharmaceutical expense assistance
1340 program shall be administered by the agency, in collaboration
1341 with the Department of Elderly Affairs and the Department of
1342 Children and Family Services.
1343 (a) The agency may adopt rules pursuant to ss. 120.536(1)
1344 and 120.54 to implement the provisions of this section.
1345 (b) By January 1 of each year, the agency shall report to
1346 the Legislature on the operation of the program. The report
1347 shall include information on the number of individuals served,
1348 use rates, and expenditures under the program.
1349 (5) NONENTITLEMENT.--The pharmaceutical expense assistance
1350 program established by this section is not an entitlement. The
1351 agency may develop a waiting list based on application dates to
1352 use in enrolling individuals when funds become available for
1353 unfilled enrollment slots.
1354 Section 21. Subsection (17) is added to section 430.04,
1355 Florida Statutes, to read:
1356 430.04 Duties and responsibilities of the Department of
1357 Elderly Affairs.--The Department of Elderly Affairs shall:
1358 (17) Be designated as a state agency that is eligible to
1359 receive federal funds for adults who are eligible for assistance
1360 through the portion of the federal Child and Adult Care Food
1361 Program for adults, which is referred to as the Adult Care Food
1362 Program, and that is responsible for establishing and
1363 administering the program. The purpose of the Adult Care Food
1364 Program is to provide nutritious and wholesome meals and snacks
1365 for adults in nonresidential day care centers or residential
1366 treatment facilities. To ensure the quality and integrity of the
1367 program, the department shall develop standards and procedures

1368 that govern sponsoring organizations and adult day care centers.
1369 The department shall follow federal requirements and may adopt
1370 any rules necessary pursuant to ss. 120.536(1) and 120.54 for
1371 the implementation of the Adult Care Food Program. With respect
1372 to the Adult Care Food Program, the department shall adopt rules
1373 pursuant to ss. 120.536(1) and 120.54 that implement relevant
1374 federal regulations, including 7 C.F.R. part 226. The rules may
1375 address, at a minimum, the program requirements and procedures
1376 identified in this subsection.
1377 Section 22. Subsection (5) of section 430.705, Florida
1378 Statutes, is amended to read:
1379 430.705 Implementation of the long-term care community
1380 diversion pilot projects.--
1381 (5) A prospective participant who applies for the long-
1382 term care community diversion pilot project and is determined by
1383 the Comprehensive Assessment Review and Evaluation for Long-Term
1384 Care Services (CARES) Program within the Department of Elderly
1385 Affairs to be medically eligible, but has not been determined
1386 financially eligible by the Department of Children and Family
1387 Services, shall be designated "Medicaid Pending." CARES shall
1388 determine each applicant's eligibility within 22 days after
1389 receiving the application. Contractors may elect to provide
1390 services to Medicaid Pending individuals until their financial
1391 eligibility is determined. If the individual is determined
1392 financially eligible, the agency shall pay the contractor that
1393 provided the services a capitated rate retroactive to the first
1394 of the month following the CARES eligibility determination. If
1395 the individual is not financially eligible for Medicaid, the
1396 contractor may terminate services and seek reimbursement from

1397 the individual. ~~In order to achieve rapid enrollment into the~~
1398 ~~program and efficient diversion of applicants from nursing home~~
1399 ~~care, the department and the agency shall allow enrollment of~~
1400 ~~Medicaid beneficiaries on the date that eligibility for the~~
1401 ~~community diversion pilot project is approved. The provider~~
1402 ~~shall receive a prorated capitated rate for those enrollees who~~
1403 ~~are enrolled after the first of each month.~~
1404 Section 23. Paragraph (b) of subsection (5) of section
1405 624.91, Florida Statutes, is amended to read:
1406 624.91 The Florida Healthy Kids Corporation Act.--
1407 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.--
1408 (b) The Florida Healthy Kids Corporation shall:
1409 1. Arrange for the collection of any family, local
1410 contributions, or employer payment or premium, in an amount to
1411 be determined by the board of directors, to provide for payment
1412 of premiums for comprehensive insurance coverage and for the
1413 actual or estimated administrative expenses.
1414 2. Arrange for the collection of any voluntary
1415 contributions to provide for payment of premiums for children
1416 who are not eligible for medical assistance under Title XXI of
1417 the Social Security Act. ~~Each fiscal year, the corporation shall~~
1418 ~~establish a local match policy for the enrollment of non-Title-~~
1419 ~~XXI-eligible children in the Healthy Kids program. By May 1 of~~
1420 ~~each year, the corporation shall provide written notification of~~
1421 ~~the amount to be remitted to the corporation for the following~~
1422 ~~fiscal year under that policy. Local match sources may include,~~
1423 ~~but are not limited to, funds provided by municipalities,~~
1424 ~~counties, school boards, hospitals, health care providers,~~
1425 ~~charitable organizations, special taxing districts, and private~~

1426 ~~organizations. The minimum local match cash contributions~~
1427 ~~required each fiscal year and local match credits shall be~~
1428 ~~determined by the General Appropriations Act. The corporation~~
1429 ~~shall calculate a county's local match rate based upon that~~
1430 ~~county's percentage of the state's total non-Title-XXI~~
1431 ~~expenditures as reported in the corporation's most recently~~
1432 ~~audited financial statement. In awarding the local match~~
1433 ~~credits, the corporation may consider factors including, but not~~
1434 ~~limited to, population density, per capita income, and existing~~
1435 ~~child-health-related expenditures and services.~~
1436 3. Subject to the provisions of s. 409.8134, accept
1437 voluntary supplemental local match contributions that comply
1438 with the requirements of Title XXI of the Social Security Act
1439 for the purpose of providing additional coverage in contributing
1440 counties under Title XXI.
1441 4. Establish the administrative and accounting procedures
1442 for the operation of the corporation.
1443 5. Establish, with consultation from appropriate
1444 professional organizations, standards for preventive health
1445 services and providers and comprehensive insurance benefits
1446 appropriate to children, provided that such standards for rural
1447 areas shall not limit primary care providers to board-certified
1448 pediatricians.
1449 6. Determine eligibility for children seeking to
1450 participate in the Title XXI-funded components of the Florida
1451 KidCare program consistent with the requirements specified in s.
1452 409.814, as well as the non-Title-XXI-eligible children as
1453 provided in subsection (3).

1454 7. Establish procedures under which providers of local
1455 match to, applicants to and participants in the program may have
1456 grievances reviewed by an impartial body and reported to the
1457 board of directors of the corporation.
1458 8. Establish participation criteria and, if appropriate,
1459 contract with an authorized insurer, health maintenance
1460 organization, or third-party administrator to provide
1461 administrative services to the corporation.
1462 9. Establish enrollment criteria which shall include
1463 penalties or waiting periods of not fewer than 60 days for
1464 reinstatement of coverage upon voluntary cancellation for
1465 nonpayment of family premiums.
1466 10. Contract with authorized insurers or any provider of
1467 health care services, meeting standards established by the
1468 corporation, for the provision of comprehensive insurance
1469 coverage to participants. Such standards shall include criteria
1470 under which the corporation may contract with more than one
1471 provider of health care services in program sites. Health plans
1472 shall be selected through a competitive bid process. The Florida
1473 Healthy Kids Corporation shall purchase goods and services in
1474 the most cost-effective manner consistent with the delivery of
1475 quality medical care. The maximum administrative cost for a
1476 Florida Healthy Kids Corporation contract shall be 15 percent.
1477 For health care contracts, the minimum medical loss ratio for a
1478 Florida Healthy Kids Corporation contract shall be 85 percent.
1479 For dental contracts, the remaining compensation to be paid to
1480 the authorized insurer or provider under a Florida Healthy Kids
1481 Corporation contract shall be no less than an amount which is 85
1482 percent of premium; to the extent any contract provision does

1483 not provide for this minimum compensation, this section shall
1484 prevail. The health plan selection criteria and scoring system,
1485 and the scoring results, shall be available upon request for
1486 inspection after the bids have been awarded.
1487 11. Establish disenrollment criteria in the event local
1488 matching funds are insufficient to cover enrollments.
1489 12. Develop and implement a plan to publicize the Florida
1490 Healthy Kids Corporation, the eligibility requirements of the
1491 program, and the procedures for enrollment in the program and to
1492 maintain public awareness of the corporation and the program.
1493 13. Secure staff necessary to properly administer the
1494 corporation. Staff costs shall be funded from state and local
1495 matching funds and such other private or public funds as become
1496 available. The board of directors shall determine the number of
1497 staff members necessary to administer the corporation.
1498 14. Provide a report annually to the Governor, Chief
1499 Financial Officer, Commissioner of Education, Senate President,
1500 Speaker of the House of Representatives, and Minority Leaders of
1501 the Senate and the House of Representatives.
1502 15. Establish benefit packages which conform to the
1503 provisions of the Florida KidCare program, as created in ss.
1504 409.810-409.820.
1505 Section 24. The Office of Program Policy Analysis and
1506 Government Accountability shall review the functions currently
1507 performed by the Comprehensive Assessment Review and Evaluation
1508 for Long-Term Care Services (CARES) Program within the
1509 Department of Elderly Affairs. The Office of Program Policy
1510 Analysis and Government Accountability shall identify the
1511 factors affecting the time currently required for CARES staff to

1512 assess an individual's eligibility for long-term care services.
1513 As part of this study, the Office of Program Policy Analysis and
1514 Government Accountability shall also examine circumstances that
1515 could delay an individual's placement into the long-term care
1516 community diversion pilot project. The Office of Program Policy
1517 Analysis and Government Accountability shall report its findings
1518 to the President of the Senate and the Speaker of the House of
1519 Representatives by February 1, 2007.
1520 Section 25. Section 409.8201, Florida Statutes, is
1521 repealed.
1522 Section 26. This act shall take effect July 1, 2006.
1523
1524 ======= T I T L E A M E N D M E N T ========
1525 Remove the entire title and insert:
1526 A bill to be entitled
1527 An act relating to health care; amending s. 391.026, F.S.;
1528 requiring the Department of Health to contract with a
1529 third-party administrator for certain services necessary
1530 to the operation of the Children's Medical Services
1531 network; authorizing the department to maintain a
1532 specified minimum reserve for the network; amending s.
1533 400.141, F.S.; providing a reference for purposes of
1534 assessing compliance with standards for staffing levels in
1535 nursing homes; amending s. 400.179, F.S.; revising the
1536 amount of a certain fee to be paid by a leasehold licensee
1537 upon transfer of ownership of a nursing facility under
1538 certain circumstances; amending s. 400.23, F.S.; revising
1539 minimum staffing requirements for nursing homes; amending
1540 s. 409.811, F.S.; deleting the definition of the term

1541 "enrollment ceiling"; amending s. 409.8134, F.S.; deleting
1542 references to enrollment ceilings for the Florida KidCare
1543 program; providing for enrollment to cease when the
1544 expenditure ceiling is reached; amending ss. 409.814 and
1545 409.818, F.S.; deleting references to enrollment ceilings
1546 for the Florida KidCare program; amending s. 409.904,
1547 F.S.; revising requirements relating to eligibility of
1548 certain women for family planning services; amending s.
1549 409.905, F.S.; revising provisions relating to the
1550 implementation of a hospitalist program; authorizing the
1551 Agency for Health Care Administration to procure
1552 hospitalist services by individual county or combined
1553 counties; requiring a qualified organization to contract
1554 with or employ board-eligible physicians in specified
1555 counties; amending s. 409.906, F.S.; revising provisions
1556 relating to optional dental, hearing, and visual services
1557 covered by Medicaid; amending s. 409.907, F.S.; revising
1558 the enrollment effective date for Medicaid providers;
1559 providing procedures for payment for certain claims for
1560 services; amending s. 409.908, F.S.; revising provisions
1561 relating to the effect of changes of ownership or of
1562 licensed operator of a Medicaid provider on reimbursement
1563 rates under certain circumstances; revising provisions to
1564 permit rather than require a certain limit on the indirect
1565 care component of the long-term care reimbursement plan;
1566 amending s. 409.9081, F.S.; revising the limitation on
1567 Medicaid recipient copayments for emergency room services;
1568 amending s. 409.911, F.S., relating to the hospital
1569 disproportionate share program; revising the method for

1570 calculating disproportionate share payments to hospitals;
1571 deleting obsolete provisions; amending s. 409.9113, F.S.;
1572 providing guidelines for distribution of disproportionate
1573 share funds to certain teaching hospitals; amending s.
1574 409.9117, F.S., relating to the primary care
1575 disproportionate share program; revising the time period
1576 during which the agency shall not distribute certain
1577 moneys; amending s. 409.912, F.S., relating to cost-
1578 effective purchasing of health care; authorizing the
1579 agency to post a preferred drug list and updates thereto
1580 on an Internet website without following the rulemaking
1581 procedures of ch. 120, F.S.; providing that adjustments
1582 for health status be considered in agency evaluations of
1583 the cost-effectiveness of Medicaid managed care plans;
1584 amending s. 409.9122, F.S.; revising enrollment limits for
1585 Medicaid recipients who are subject to mandatory
1586 assignment to managed care plans and MediPass; creating s.
1587 409.9301, F.S.; establishing a pharmaceutical expense
1588 assistance program; providing eligibility requirements;
1589 providing for the Agency for Health Care Administration to
1590 pay certain coinsurance and deductibles for specified
1591 medications; requiring the agency, in collaboration with
1592 the Department of Elderly Affairs and the Department of
1593 Children and Family Services, to administer the program;
1594 authorizing the agency to adopt rules; requiring a report
1595 to the Legislature; declaring that the program is not an
1596 entitlement; providing for a waiting list; amending s.
1597 430.04, F.S.; designating the Department of Elderly
1598 Affairs as the state agency to receive federal funds for

1599 adults eligible for assistance through the Adult Care Food
1600 Program; requiring the department to develop standards and
1601 procedures to govern sponsoring organizations and adult
1602 day care centers for certain purposes; providing
1603 rulemaking authority to the department; amending s.
1604 430.705, F.S., relating to implementation of the long-term
1605 care community diversion pilot projects; providing for
1606 certain prospective participants in the pilot projects to
1607 be designated "Medicaid Pending" while eligibility is
1608 determined; providing conditions for reimbursement of
1609 contractors; amending s. 624.91, F.S.; deleting provisions
1610 requiring the Florida Healthy Kids Corporation to
1611 establish a local match policy for the enrollment of
1612 certain children in the Healthy Kids program; requiring
1613 the Office of Program Policy Analysis and Government
1614 Accountability to review functions performed by the
1615 Comprehensive Assessment Review and Evaluation for Long-
1616 Term Care Services Program; requiring a report to the
1617 Legislature; repealing s. 409.8201, F.S., relating to the
1618 enrollment ceiling for the non-Medicaid portion of the
1619 Florida KidCare program; providing an effective date.