1 A bill to be entitled
2 An act relating to health care; amending s. 391.026, F.S.;
3 requiring the Department of Health to contract with a
4 third-party administrator for certain services necessary
5 to the operation of the Children's Medical Services
6 network; authorizing the department to maintain a
7 specified minimum reserve for the network; amending s.
8 400.141, F.S.; providing a reference for purposes of
9 assessing compliance with standards for staffing levels in
10 nursing homes; amending s. 400.179, F.S.; revising the
11 amount of a certain fee to be paid by a leasehold licensee
12 upon transfer of ownership of a nursing facility under
13 certain circumstances; amending s. 400.23, F.S.; revising
14 minimum staffing requirements for nursing homes; amending
15 s. 409.811, F.S.; deleting the definition of the term
16 "enrollment ceiling"; amending s. 409.8134, F.S.; deleting
17 references to enrollment ceilings for the Florida KidCare
18 program; providing for enrollment to cease when the
19 expenditure ceiling is reached; amending ss. 409.814 and
20 409.818, F.S.; deleting references to enrollment ceilings
21 for the Florida KidCare program; amending s. 409.904,
22 F.S.; revising requirements relating to eligibility of
23 certain women for family planning services; amending s.
24 409.905, F.S.; revising provisions relating to the
25 implementation of a hospitalist program; authorizing the
26 Agency for Health Care Administration to procure
27 hospitalist services by individual county or combined
28 counties; requiring a qualified organization to contract

29 with or employ board-eligible physicians in specified
30 counties; amending s. 409.906, F.S.; revising provisions
31 relating to optional dental, hearing, and visual services
32 covered by Medicaid; amending s. 409.907, F.S.; revising
33 the enrollment effective date for Medicaid providers;
34 providing procedures for payment for certain claims for
35 services; amending s. 409.908, F.S.; revising provisions
36 relating to the effect of changes of ownership or of
37 licensed operator of a Medicaid provider on reimbursement
38 rates under certain circumstances; revising provisions to
39 permit rather than require a certain limit on the indirect
40 care component of the long-term care reimbursement plan;
41 amending s. 409.9081, F.S.; revising the limitation on
42 Medicaid recipient copayments for emergency room services;
43 amending s. 409.911, F.S., relating to the hospital
44 disproportionate share program; revising the method for
45 calculating disproportionate share payments to hospitals;
46 deleting obsolete provisions; amending s. 409.9113, F.S.;
47 providing guidelines for distribution of disproportionate
48 share funds to certain teaching hospitals; amending s.
49 409.9117, F.S., relating to the primary care
50 disproportionate share program; revising the time period
51 during which the agency shall not distribute certain
52 moneys; amending s. 409.912, F.S., relating to cost-
53 effective purchasing of health care; authorizing the
54 agency to post a preferred drug list and updates thereto
55 on an Internet website without following the rulemaking
56 procedures of ch. 120, F.S.; providing that adjustments

57 for health status be considered in agency evaluations of
58 the cost-effectiveness of Medicaid managed care plans;
59 amending s. 409.9122, F.S.; revising enrollment limits for
60 Medicaid recipients who are subject to mandatory
61 assignment to managed care plans and MediPass; creating s.
62 409.9301, F.S.; establishing a pharmaceutical expense
63 assistance program; providing eligibility requirements;
64 providing for the Agency for Health Care Administration to
65 pay certain coinsurance and deductibles for specified
66 medications; requiring the agency, in collaboration with
67 the Department of Elderly Affairs and the Department of
68 Children and Family Services, to administer the program;
69 authorizing the agency to adopt rules; requiring a report
70 to the Legislature; declaring that the program is not an
71 entitlement; providing for a waiting list; amending s.
72 430.04, F.S.; designating the Department of Elderly
73 Affairs as the state agency to receive federal funds for
74 adults eligible for assistance through the Adult Care Food
75 Program; requiring the department to develop standards and
76 procedures to govern sponsoring organizations and adult
77 day care centers for certain purposes; providing
78 rulemaking authority to the department; amending s.
79 430.705, F.S., relating to implementation of the long-term
80 care community diversion pilot projects; providing for
81 certain prospective participants in the pilot projects to
82 be designated "Medicaid Pending" while eligibility is
83 determined; providing conditions for reimbursement of
84 contractors; amending s. 624.91, F.S.; deleting provisions

85 requiring the Florida Healthy Kids Corporation to
86 establish a local match policy for the enrollment of
87 certain children in the Healthy Kids program; requiring
88 the Office of Program Policy Analysis and Government
89 Accountability to review functions performed by the
90 Comprehensive Assessment Review and Evaluation for Long-
91 Term Care Services Program; requiring a report to the
92 Legislature; repealing s. 409.8201, F.S., relating to the
93 enrollment ceiling for the non-Medicaid portion of the
94 Florida KidCare program; providing an effective date.
95
96 Be It Enacted by the Legislature of the State of Florida:
97
98 Section 1. Subsection (16) of section 391.026, Florida
99 Statutes, is amended to read:
100 391.026 Powers and duties of the department.--The
101 department shall have the following powers, duties, and
102 responsibilities:
103 (16) To receive and manage health care premiums,
104 capitation payments, and funds from federal, state, local, and
105 private entities for the program. The department may contract
106 with a third-party administrator for processing claims,
107 monitoring medical expenses, and other related services
108 necessary to the efficient and cost-effective operation of the
109 Children's Medical Services network. The department is
110 authorized to maintain a minimum reserve for the Children's
111 Medical Services network in an amount that is the greater of:
112 (a) Ten percent of total projected expenditures for Title

113 XIX-funded and Title XXI-funded children; or
114 (b) Two percent of total annualized payments from the
115 Agency for Health Care Administration for Title XIX and Title
116 XXI of the Social Security Act.
117 Section 2. Paragraph (e) of subsection (15) of section
118 400.141, Florida Statutes, is amended to read:
119 400.141 Administration and management of nursing home
120 facilities.--Every licensed facility shall comply with all
121 applicable standards and rules of the agency and shall:
122 (15) Submit semiannually to the agency, or more frequently
123 if requested by the agency, information regarding facility
124 staff-to-resident ratios, staff turnover, and staff stability,
125 including information regarding certified nursing assistants,
126 licensed nurses, the director of nursing, and the facility
127 administrator. For purposes of this reporting:
128 (e) A nursing facility which does not have a conditional
129 license may be cited for failure to comply with the standards in
130 s. 400.23(3)(a)1.a. only if it has failed to meet those
131 standards on 2 consecutive days or if it has failed to meet at
132 least 97 percent of those standards on any one day.
133
134 Nothing in this section shall limit the agency's ability to
135 impose a deficiency or take other actions if a facility does not
136 have enough staff to meet the residents' needs.
137
138 Facilities that have been awarded a Gold Seal under the program
139 established in s. 400.235 may develop a plan to provide
140 certified nursing assistant training as prescribed by federal

141 regulations and state rules and may apply to the agency for
142 approval of their program.
143 Section 3. Paragraph (d) of subsection (5) of section
144 400.179, Florida Statutes, is amended to read:
145 400.179 Sale or transfer of ownership of a nursing
146 facility; liability for Medicaid underpayments and
147 overpayments.--
148 (5) Because any transfer of a nursing facility may expose
149 the fact that Medicaid may have underpaid or overpaid the
150 transferor, and because in most instances, any such underpayment
151 or overpayment can only be determined following a formal field
152 audit, the liabilities for any such underpayments or
153 overpayments shall be as follows:
154 (d) Where the transfer involves a facility that has been
155 leased by the transferor:
156 1. The transferee shall, as a condition to being issued a
157 license by the agency, acquire, maintain, and provide proof to
158 the agency of a bond with a term of 30 months, renewable
159 annually, in an amount not less than the total of 3 months'
160 ~~months~~ Medicaid payments to the facility computed on the basis
161 of the preceding 12-month average Medicaid payments to the
162 facility.
163 2. A leasehold licensee may meet the requirements of
164 subparagraph 1. by payment of a nonrefundable fee, paid at
165 initial licensure, paid at the time of any subsequent change of
166 ownership, and paid at the time of any subsequent annual license
167 renewal, in the amount of 1 ~~2~~ percent of the total of 3 months'
168 Medicaid payments to the facility computed on the basis of the

169 preceding 12-month average Medicaid payments to the facility. If
170 a preceding 12-month average is not available, projected
171 Medicaid payments may be used. The fee shall be deposited into
172 the Health Care Trust Fund and shall be accounted for separately
173 as a Medicaid nursing home overpayment account. These fees shall
174 be used at the sole discretion of the agency to repay nursing
175 home Medicaid overpayments. Payment of this fee shall not
176 release the licensee from any liability for any Medicaid
177 overpayments, nor shall payment bar the agency from seeking to
178 recoup overpayments from the licensee and any other liable
179 party. As a condition of exercising this lease bond alternative,
180 licensees paying this fee must maintain an existing lease bond
181 through the end of the 30-month term period of that bond. The
182 agency is herein granted specific authority to promulgate all
183 rules pertaining to the administration and management of this
184 account, including withdrawals from the account, subject to
185 federal review and approval. This provision shall take effect
186 upon becoming law and shall apply to any leasehold license
187 application. The financial viability of the Medicaid nursing
188 home overpayment account shall be determined by the agency
189 through annual review of the account balance and the amount of
190 total outstanding, unpaid Medicaid overpayments owing from
191 leasehold licensees to the agency as determined by final agency
192 audits.
193 3. The leasehold licensee may meet the bond requirement
194 through other arrangements acceptable to the agency. The agency
195 is herein granted specific authority to promulgate rules
196 pertaining to lease bond arrangements.

197 4. All existing nursing facility licensees, operating the
198 facility as a leasehold, shall acquire, maintain, and provide
199 proof to the agency of the 30-month bond required in
200 subparagraph 1., above, on and after July 1, 1993, for each
201 license renewal.
202 5. It shall be the responsibility of all nursing facility
203 operators, operating the facility as a leasehold, to renew the
204 30-month bond and to provide proof of such renewal to the agency
205 annually at the time of application for license renewal.
206 6. Any failure of the nursing facility operator to
207 acquire, maintain, renew annually, or provide proof to the
208 agency shall be grounds for the agency to deny, cancel, revoke,
209 or suspend the facility license to operate such facility and to
210 take any further action, including, but not limited to,
211 enjoining the facility, asserting a moratorium, or applying for
212 a receiver, deemed necessary to ensure compliance with this
213 section and to safeguard and protect the health, safety, and
214 welfare of the facility's residents. A lease agreement required
215 as a condition of bond financing or refinancing under s. 154.213
216 by a health facilities authority or required under s. 159.30 by
217 a county or municipality is not a leasehold for purposes of this
218 paragraph and is not subject to the bond requirement of this
219 paragraph.
220 Section 4. Paragraph (a) of subsection (3) of section
221 400.23, Florida Statutes, is amended to read:
222 400.23 Rules; evaluation and deficiencies; licensure
223 status.--
224 (3)(a)1. The agency shall adopt rules providing minimum

225 staffing requirements for nursing homes. These requirements
226 shall include, for each nursing home facility:~~,~~
227 a. A minimum certified nursing assistant staffing of ~~2.3~~
228 ~~hours of direct care per resident per day beginning January 1,~~
229 ~~2002, increasing to~~ 2.6 hours of direct care per resident per
230 day beginning January 1, 2003, and increasing to 2.7 ~~2.9~~ hours
231 of direct care per resident per day beginning January 1, 2007
232 ~~July 1, 2006~~. Beginning January 1, 2002, no facility shall staff
233 below one certified nursing assistant per 20 residents, and a
234 minimum licensed nursing staffing of 1.0 hour of direct ~~resident~~
235 care per resident per day but never below one licensed nurse per
236 40 residents.
237 b. Beginning January 1, 2007, a minimum weekly average
238 certified nursing assistant staffing of 2.9 hours of direct care
239 per resident per day. For the purpose of this sub-subparagraph,
240 a week is defined as Sunday through Saturday.
241 2. Nursing assistants employed under s. 400.211(2) may be
242 included in computing the staffing ratio for certified nursing
243 assistants only if their job responsibilities include only
244 nursing-assistant-related duties ~~they provide nursing assistance~~
245 ~~services to residents on a full-time basis~~.
246 3. Each nursing home must document compliance with
247 staffing standards as required under this paragraph and post
248 daily the names of staff on duty for the benefit of facility
249 residents and the public.
250 4. The agency shall recognize the use of licensed nurses
251 for compliance with minimum staffing requirements for certified
252 nursing assistants, provided that the facility otherwise meets

253 the minimum staffing requirements for licensed nurses and that
254 the licensed nurses are performing the duties of a certified
255 nursing assistant. Unless otherwise approved by the agency,
256 licensed nurses counted toward the minimum staffing requirements
257 for certified nursing assistants must exclusively perform the
258 duties of a certified nursing assistant for the entire shift and
259 not also be counted toward the minimum staffing requirements for
260 licensed nurses. If the agency approved a facility's request to
261 use a licensed nurse to perform both licensed nursing and
262 certified nursing assistant duties, the facility must allocate
263 the amount of staff time specifically spent on certified nursing
264 assistant duties for the purpose of documenting compliance with
265 minimum staffing requirements for certified and licensed nursing
266 staff. In no event may the hours of a licensed nurse with dual
267 job responsibilities be counted twice.
268 Section 5. Subsections (12) through (27) of section
269 409.811, Florida Statutes, are renumbered as subsections (11)
270 through (26), respectively, and present subsection (11) of that
271 section is amended to read:
272 409.811 Definitions relating to Florida KidCare Act.--As
273 used in ss. 409.810-409.820, the term:
274 ~~(11) "Enrollment ceiling" means the maximum number of~~
275 ~~children receiving premium assistance payments, excluding~~
276 ~~children enrolled in Medicaid, that may be enrolled at any time~~
277 ~~in the Florida KidCare program. The maximum number shall be~~
278 ~~established annually in the General Appropriations Act or by~~
279 ~~general law.~~
280 Section 6. Subsections (1) and (2) of section 409.8134,

281 Florida Statutes, are amended to read:
282 409.8134 Program ~~enrollment and~~ expenditure ceiling
283 ~~ceilings~~.--
284 (1) Except for the Medicaid program, a ceiling shall be
285 placed on annual federal and state expenditures for ~~and on~~
286 ~~enrollment in~~ the Florida KidCare program as provided each year
287 in the General Appropriations Act.
288 (2) The Florida KidCare program may conduct enrollment at
289 any time throughout the year for the purpose of enrolling
290 children eligible for all program components listed in s.
291 409.813 except Medicaid. The four Florida KidCare administrators
292 shall work together to ensure that the year-round enrollment
293 period is announced statewide. Eligible children shall be
294 enrolled on a first-come, first-served basis using the date the
295 enrollment application is received. Enrollment shall immediately
296 cease when the expenditure ~~enrollment~~ ceiling is reached. Year-
297 round enrollment shall only be held if the Social Services
298 Estimating Conference determines that sufficient federal and
299 state funds will be available to finance the increased
300 enrollment through federal fiscal year 2007. Any individual who
301 is not enrolled must reapply by submitting a new application.
302 The application for the Florida KidCare program shall be valid
303 for a period of 120 days after the date it was received. At the
304 end of the 120-day period, if the applicant has not been
305 enrolled in the program, the application shall be invalid and
306 the applicant shall be notified of the action. The applicant may
307 resubmit the application after notification of the action taken
308 by the program. Except for the Medicaid program, whenever the

309 Social Services Estimating Conference determines that there are
310 presently, or will be by the end of the current fiscal year,
311 insufficient funds to finance the current or projected
312 enrollment in the Florida KidCare program, all additional
313 enrollment must cease and additional enrollment may not resume
314 until sufficient funds are available to finance such enrollment.
315 Section 7. Paragraph (d) of subsection (5) of section
316 409.814, Florida Statutes, is amended to read:
317 409.814 Eligibility.--A child who has not reached 19 years
318 of age whose family income is equal to or below 200 percent of
319 the federal poverty level is eligible for the Florida KidCare
320 program as provided in this section. For enrollment in the
321 Children's Medical Services Network, a complete application
322 includes the medical or behavioral health screening. If,
323 subsequently, an individual is determined to be ineligible for
324 coverage, he or she must immediately be disenrolled from the
325 respective Florida KidCare program component.
326 (5) A child whose family income is above 200 percent of
327 the federal poverty level or a child who is excluded under the
328 provisions of subsection (4) may participate in the Florida
329 KidCare program, excluding the Medicaid program, but is subject
330 to the following provisions:
331 ~~(d) Children described in this subsection are not counted~~
332 ~~in the annual enrollment ceiling for the Florida KidCare~~
333 ~~program.~~
334 Section 8. Paragraphs (c) through (g) of subsection (3) of
335 section 409.818, Florida Statutes, are redesignated as
336 paragraphs (b) through (f), respectively, and present paragraphs

337 (b) and (g) of subsection (3) of that section are amended to
338 read:
339 409.818 Administration.--In order to implement ss.
340 409.810-409.820, the following agencies shall have the following
341 duties:
342 (3) The Agency for Health Care Administration, under the
343 authority granted in s. 409.914(1), shall:
344 ~~(b) Annually calculate the program enrollment ceiling~~
345 ~~based on estimated per child premium assistance payments and the~~
346 ~~estimated appropriation available for the program.~~
347 <u>(f)</u>~~(g)~~ Adopt rules necessary for calculating premium
348 assistance payment levels, ~~calculating the program enrollment~~
349 ~~ceiling,~~ making premium assistance payments, monitoring access
350 and quality assurance standards, investigating and resolving
351 complaints and grievances, administering the Medikids program,
352 and approving health benefits coverage.
353
354 The agency is designated the lead state agency for Title XXI of
355 the Social Security Act for purposes of receipt of federal
356 funds, for reporting purposes, and for ensuring compliance with
357 federal and state regulations and rules.
358 Section 9. Subsection (5) of section 409.904, Florida
359 Statutes, is amended to read:
360 409.904 Optional payments for eligible persons.--The
361 agency may make payments for medical assistance and related
362 services on behalf of the following persons who are determined
363 to be eligible subject to the income, assets, and categorical
364 eligibility tests set forth in federal and state law. Payment on

365 behalf of these Medicaid eligible persons is subject to the
366 availability of moneys and any limitations established by the
367 General Appropriations Act or chapter 216.
368 (5) Subject to specific federal authorization, a
369 ~~postpartum~~ woman living in a family that has an income that is
370 at or below 185 percent of the most current federal poverty
371 level is eligible for family planning services as specified in
372 s. 409.905(3) for a period of up to 24 months following a loss
373 of Medicaid benefits ~~pregnancy for which Medicaid paid for~~
374 ~~pregnancy-related services~~.
375 Section 10. Paragraph (d) of subsection (5) of section
376 409.905, Florida Statutes, is amended to read:
377 409.905 Mandatory Medicaid services.--The agency may make
378 payments for the following services, which are required of the
379 state by Title XIX of the Social Security Act, furnished by
380 Medicaid providers to recipients who are determined to be
381 eligible on the dates on which the services were provided. Any
382 service under this section shall be provided only when medically
383 necessary and in accordance with state and federal law.
384 Mandatory services rendered by providers in mobile units to
385 Medicaid recipients may be restricted by the agency. Nothing in
386 this section shall be construed to prevent or limit the agency
387 from adjusting fees, reimbursement rates, lengths of stay,
388 number of visits, number of services, or any other adjustments
389 necessary to comply with the availability of moneys and any
390 limitations or directions provided for in the General
391 Appropriations Act or chapter 216.
392 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for

393 all covered services provided for the medical care and treatment
394 of a recipient who is admitted as an inpatient by a licensed
395 physician or dentist to a hospital licensed under part I of
396 chapter 395. However, the agency shall limit the payment for
397 inpatient hospital services for a Medicaid recipient 21 years of
398 age or older to 45 days or the number of days necessary to
399 comply with the General Appropriations Act.
400 (d) The agency shall implement a hospitalist program in
401 nonteaching ~~certain high-volume participating~~ hospitals, select
402 counties, or statewide. The program shall require hospitalists
403 to ~~authorize and~~ manage Medicaid recipients' hospital admissions
404 and lengths of stay. Individuals who are dually eligible for
405 Medicare and Medicaid are exempted from this requirement.
406 Medicaid participating physicians and other practitioners with
407 hospital admitting privileges shall coordinate and review
408 admissions of Medicaid recipients with the hospitalist. The
409 agency may competitively bid a contract for selection of a
410 single qualified organization to provide hospitalist services.
411 The agency may procure hospitalist services by individual county
412 or may combine counties in a single procurement. The qualified
413 organization shall contract with or employ board-eligible ~~board~~
414 ~~certified~~ physicians in Miami-Dade, Palm Beach, Hillsborough,
415 Pasco, and Pinellas Counties ~~who are full-time dedicated~~
416 ~~employees of the contractor and have no outside practice~~. ~~Where~~
417 ~~used, the hospitalist program shall replace the existing~~
418 ~~hospital utilization review program.~~ The agency is authorized to
419 seek federal waivers to implement this program.
420 Section 11. Paragraph (b) of subsection (1) and

421 subsections (12) and (23) of section 409.906, Florida Statutes,
422 are amended to read:
423 409.906 Optional Medicaid services.--Subject to specific
424 appropriations, the agency may make payments for services which
425 are optional to the state under Title XIX of the Social Security
426 Act and are furnished by Medicaid providers to recipients who
427 are determined to be eligible on the dates on which the services
428 were provided. Any optional service that is provided shall be
429 provided only when medically necessary and in accordance with
430 state and federal law. Optional services rendered by providers
431 in mobile units to Medicaid recipients may be restricted or
432 prohibited by the agency. Nothing in this section shall be
433 construed to prevent or limit the agency from adjusting fees,
434 reimbursement rates, lengths of stay, number of visits, or
435 number of services, or making any other adjustments necessary to
436 comply with the availability of moneys and any limitations or
437 directions provided for in the General Appropriations Act or
438 chapter 216. If necessary to safeguard the state's systems of
439 providing services to elderly and disabled persons and subject
440 to the notice and review provisions of s. 216.177, the Governor
441 may direct the Agency for Health Care Administration to amend
442 the Medicaid state plan to delete the optional Medicaid service
443 known as "Intermediate Care Facilities for the Developmentally
444 Disabled." Optional services may include:
445 (1) ADULT DENTAL SERVICES.--
446 (b) Beginning July 1, 2006 ~~January 1, 2005~~, the agency may
447 pay for full or partial dentures, the procedures required to
448 seat full or partial dentures, and the repair and reline of full

449 or partial dentures, provided by or under the direction of a
450 licensed dentist, for a recipient who is 21 years of age or
451 older.
452 (12) ~~CHILDREN'S~~ HEARING SERVICES.--The agency may pay for
453 hearing and related services, including hearing evaluations,
454 hearing aid devices, dispensing of the hearing aid, and related
455 repairs, if provided to a recipient ~~younger than 21 years of age~~
456 by a licensed hearing aid specialist, otolaryngologist,
457 otologist, audiologist, or physician.
458 (23) ~~CHILDREN'S~~ VISUAL SERVICES.--The agency may pay for
459 visual examinations, eyeglasses, and eyeglass repairs for a
460 recipient ~~younger than 21 years of age,~~ if they are prescribed
461 by a licensed physician specializing in diseases of the eye or
462 by a licensed optometrist. Eyeglasses for adult recipients shall
463 be limited to two pairs per year per recipient, except a third
464 pair may be provided after prior authorization.
465 Section 12. Paragraph (a) of subsection (9) of section
466 409.907, Florida Statutes, is amended to read:
467 409.907 Medicaid provider agreements.--The agency may make
468 payments for medical assistance and related services rendered to
469 Medicaid recipients only to an individual or entity who has a
470 provider agreement in effect with the agency, who is performing
471 services or supplying goods in accordance with federal, state,
472 and local law, and who agrees that no person shall, on the
473 grounds of handicap, race, color, or national origin, or for any
474 other reason, be subjected to discrimination under any program
475 or activity for which the provider receives payment from the
476 agency.

477 (9) Upon receipt of a completed, signed, and dated
478 application, and completion of any necessary background
479 investigation and criminal history record check, the agency must
480 either:
481 (a) Enroll the applicant as a Medicaid provider ~~no earlier~~
482 ~~than the effective date of the approval of the provider~~
483 ~~application. With respect to providers who were recently granted~~
484 ~~a change of ownership and those who primarily provide emergency~~
485 ~~medical services transportation or emergency services and care~~
486 ~~pursuant to s. 395.1041 or s. 401.45, or services provided by~~
487 ~~entities under s. 409.91255, and out-of-state providers,~~ upon
488 approval of the provider application.~~,~~ The enrollment effective
489 date shall be ~~of approval is considered to be~~ the date the
490 agency receives the provider application. Payment for any claims
491 for services provided to Medicaid recipients between the date of
492 receipt of the application and the date of approval is
493 contingent on applying any and all applicable audits and edits
494 contained in the agency's claims adjudication and payment
495 processing systems; or
496 Section 13. Paragraph (b) of subsection (2) of section
497 409.908, Florida Statutes, is amended to read:
498 409.908 Reimbursement of Medicaid providers.--Subject to
499 specific appropriations, the agency shall reimburse Medicaid
500 providers, in accordance with state and federal law, according
501 to methodologies set forth in the rules of the agency and in
502 policy manuals and handbooks incorporated by reference therein.
503 These methodologies may include fee schedules, reimbursement
504 methods based on cost reporting, negotiated fees, competitive

505 bidding pursuant to s. 287.057, and other mechanisms the agency
506 considers efficient and effective for purchasing services or
507 goods on behalf of recipients. If a provider is reimbursed based
508 on cost reporting and submits a cost report late and that cost
509 report would have been used to set a lower reimbursement rate
510 for a rate semester, then the provider's rate for that semester
511 shall be retroactively calculated using the new cost report, and
512 full payment at the recalculated rate shall be effected
513 retroactively. Medicare-granted extensions for filing cost
514 reports, if applicable, shall also apply to Medicaid cost
515 reports. Payment for Medicaid compensable services made on
516 behalf of Medicaid eligible persons is subject to the
517 availability of moneys and any limitations or directions
518 provided for in the General Appropriations Act or chapter 216.
519 Further, nothing in this section shall be construed to prevent
520 or limit the agency from adjusting fees, reimbursement rates,
521 lengths of stay, number of visits, or number of services, or
522 making any other adjustments necessary to comply with the
523 availability of moneys and any limitations or directions
524 provided for in the General Appropriations Act, provided the
525 adjustment is consistent with legislative intent.
526 (2)
527 (b) Subject to any limitations or directions provided for
528 in the General Appropriations Act, the agency shall establish
529 and implement a Florida Title XIX Long-Term Care Reimbursement
530 Plan (Medicaid) for nursing home care in order to provide care
531 and services in conformance with the applicable state and
532 federal laws, rules, regulations, and quality and safety

533 standards and to ensure that individuals eligible for medical
534 assistance have reasonable geographic access to such care.
535 1. Changes of ownership or of licensed operator <u>may or may</u>
536 ~~do~~ not qualify for increases in reimbursement rates associated
537 with the change of ownership or of licensed operator. The agency
538 <u>may</u> ~~shall~~ amend the Title XIX Long Term Care Reimbursement Plan
539 to provide that the initial nursing home reimbursement rates,
540 for the operating, patient care, and MAR components, associated
541 with related and unrelated party changes of ownership or
542 licensed operator filed on or after September 1, 2001, are
543 equivalent to the previous owner's reimbursement rate.
544 2. The agency shall amend the long-term care reimbursement
545 plan and cost reporting system to create direct care and
546 indirect care subcomponents of the patient care component of the
547 per diem rate. These two subcomponents together shall equal the
548 patient care component of the per diem rate. Separate cost-based
549 ceilings shall be calculated for each patient care subcomponent.
550 The direct care subcomponent of the per diem rate shall be
551 limited by the cost-based class ceiling, and the indirect care
552 subcomponent <u>may</u> ~~shall~~ be limited by the lower of the cost-based
553 class ceiling, the target rate class ceiling, or the individual
554 provider target.
555 3. The direct care subcomponent shall include salaries and
556 benefits of direct care staff providing nursing services
557 including registered nurses, licensed practical nurses, and
558 certified nursing assistants who deliver care directly to
559 residents in the nursing home facility. This excludes nursing
560 administration, minimum data set, and care plan coordinators,

561 staff development, and staffing coordinator.
562 4. All other patient care costs shall be included in the
563 indirect care cost subcomponent of the patient care per diem
564 rate. There shall be no costs directly or indirectly allocated
565 to the direct care subcomponent from a home office or management
566 company.
567 5. On July 1 of each year, the agency shall report to the
568 Legislature direct and indirect care costs, including average
569 direct and indirect care costs per resident per facility and
570 direct care and indirect care salaries and benefits per category
571 of staff member per facility.
572 6. In order to offset the cost of general and professional
573 liability insurance, the agency shall amend the plan to allow
574 for interim rate adjustments to reflect increases in the cost of
575 general or professional liability insurance for nursing homes.
576 This provision shall be implemented to the extent existing
577 appropriations are available.
578
579 It is the intent of the Legislature that the reimbursement plan
580 achieve the goal of providing access to health care for nursing
581 home residents who require large amounts of care while
582 encouraging diversion services as an alternative to nursing home
583 care for residents who can be served within the community. The
584 agency shall base the establishment of any maximum rate of
585 payment, whether overall or component, on the available moneys
586 as provided for in the General Appropriations Act. The agency
587 may base the maximum rate of payment on the results of
588 scientifically valid analysis and conclusions derived from

589 objective statistical data pertinent to the particular maximum
590 rate of payment.
591 Section 14. Paragraph (c) of subsection (1) of section
592 409.9081, Florida Statutes, is amended to read:
593 409.9081 Copayments.--
594 (1) The agency shall require, subject to federal
595 regulations and limitations, each Medicaid recipient to pay at
596 the time of service a nominal copayment for the following
597 Medicaid services:
598 (c) Hospital emergency department visits for nonemergency
599 care: 5 percent of up to the first $300 of the Medicaid payment
600 for emergency room services, not to exceed $15 ~~for each~~
601 ~~emergency department visit~~.
602 Section 15. Subsections (2), (3), and (4) of section
603 409.911, Florida Statutes, are amended to read:
604 409.911 Disproportionate share program.--Subject to
605 specific allocations established within the General
606 Appropriations Act and any limitations established pursuant to
607 chapter 216, the agency shall distribute, pursuant to this
608 section, moneys to hospitals providing a disproportionate share
609 of Medicaid or charity care services by making quarterly
610 Medicaid payments as required. Notwithstanding the provisions of
611 s. 409.915, counties are exempt from contributing toward the
612 cost of this special reimbursement for hospitals serving a
613 disproportionate share of low-income patients.
614 (2) The Agency for Health Care Administration shall use
615 the following actual audited data to determine the Medicaid days
616 and charity care to be used in calculating the disproportionate

share payment:

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

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

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

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

$$DSHP = (HMD/TMSD) \times \$1 \text{ million}$$

Where:

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSD = total state Medicaid days.

645

646 Any funds not allocated to hospitals qualifying under this
647 section shall be redistributed to the non-state government owned
648 or operated hospitals with greater than 3,100 ~~3,300~~ Medicaid
649 days.
650 (4) The following formulas shall be used to pay
651 disproportionate share dollars to public hospitals:
652 (a) For state mental health hospitals:
653

654 DSHP = (HMD/TMDMH) x TAAMH

655

656 shall be the difference between the federal cap for Institutions
657 for Mental Diseases and the amounts paid under the mental health
658 disproportionate share program.
659

660 Where:
661 DSHP = disproportionate share hospital payment.
662 HMD = hospital Medicaid days.
663 TMDHH = total Medicaid days for state mental health
664 hospitals.
665 TAAMH = total amount available for mental health hospitals.
666 (b) For non-state government owned or operated hospitals
667 with 3,100 ~~3,300~~ or more Medicaid days:
668

669 DSHP = [(.82 x HCCD/TCCD) + (.18 x HMD/TMD)]
670 x TAAPH
671 TAAPH = TAA - TAAMH
672

673 Where:
674 TAA = total available appropriation.
675 TAAPH = total amount available for public hospitals.
676 DSHP = disproportionate share hospital payments.
677 HMD = hospital Medicaid days.
678 TMD = total state Medicaid days for public hospitals.
679 HCCD = hospital charity care dollars.
680 TCCD = total state charity care dollars for public non-
681 state hospitals.
682
683 ~~1. For the 2005-2006 state fiscal year only, the DSHP for~~
684 ~~the public nonstate hospitals shall be computed using a weighted~~
685 ~~average of the disproportionate share payments for the 2004-2005~~
686 ~~state fiscal year which uses an average of the 1998, 1999, and~~
687 ~~2000 audited disproportionate share data and the~~
688 ~~disproportionate share payments for the 2005-2006 state fiscal~~
689 ~~year as computed using the formula above and using the average~~
690 ~~of the 1999, 2000, and 2001 audited disproportionate share data.~~
691 ~~The final DSHP for the public nonstate hospitals shall be~~
692 ~~computed as an average using the calculated payments for the~~
693 ~~2005-2006 state fiscal year weighted at 65 percent and the~~
694 ~~disproportionate share payments for the 2004-2005 state fiscal~~
695 ~~year weighted at 35 percent.~~
696 ~~2.~~ The TAAPH shall be reduced by $6,365,257 before
697 computing the DSHP for each public hospital. The $6,365,257
698 shall be distributed equally between the public hospitals that
699 are also designated statutory teaching hospitals.
700 (c) For non-state government owned or operated hospitals

701 with less than 3,100 ~~3,300~~ Medicaid days, a total of $750,000
702 shall be distributed equally among these hospitals.
703 Section 16. Section 409.9113, Florida Statutes, is amended
704 to read:
705 409.9113 Disproportionate share program for teaching
706 hospitals.--In addition to the payments made under ss. 409.911
707 and 409.9112, the Agency for Health Care Administration shall
708 make disproportionate share payments to statutorily defined
709 teaching hospitals for their increased costs associated with
710 medical education programs and for tertiary health care services
711 provided to the indigent. This system of payments shall conform
712 with federal requirements and shall distribute funds in each
713 fiscal year for which an appropriation is made by making
714 quarterly Medicaid payments. Notwithstanding s. 409.915,
715 counties are exempt from contributing toward the cost of this
716 special reimbursement for hospitals serving a disproportionate
717 share of low-income patients. For the state fiscal year 2006-
718 2007 ~~2005-2006~~, the agency shall ~~not~~ distribute the moneys
719 provided in the General Appropriations Act to statutorily
720 defined teaching hospitals and family practice teaching
721 hospitals under the teaching hospital disproportionate share
722 program. The funds provided for statutorily defined teaching
723 hospitals shall be distributed in the same proportion as the
724 state fiscal year 2003-2004 teaching hospital disproportionate
725 share funds were distributed. The funds provided for family
726 practice teaching hospitals shall be distributed equally among
727 family practice teaching hospitals.
728 (1) On or before September 15 of each year, the Agency for

729 Health Care Administration shall calculate an allocation
730 fraction to be used for distributing funds to state statutory
731 teaching hospitals. Subsequent to the end of each quarter of the
732 state fiscal year, the agency shall distribute to each statutory
733 teaching hospital, as defined in s. 408.07, an amount determined
734 by multiplying one-fourth of the funds appropriated for this
735 purpose by the Legislature times such hospital's allocation
736 fraction. The allocation fraction for each such hospital shall
737 be determined by the sum of three primary factors, divided by
738 three. The primary factors are:
739 (a) The number of nationally accredited graduate medical
740 education programs offered by the hospital, including programs
741 accredited by the Accreditation Council for Graduate Medical
742 Education and the combined Internal Medicine and Pediatrics
743 programs acceptable to both the American Board of Internal
744 Medicine and the American Board of Pediatrics at the beginning
745 of the state fiscal year preceding the date on which the
746 allocation fraction is calculated. The numerical value of this
747 factor is the fraction that the hospital represents of the total
748 number of programs, where the total is computed for all state
749 statutory teaching hospitals.
750 (b) The number of full-time equivalent trainees in the
751 hospital, which comprises two components:
752 1. The number of trainees enrolled in nationally
753 accredited graduate medical education programs, as defined in
754 paragraph (a). Full-time equivalents are computed using the
755 fraction of the year during which each trainee is primarily
756 assigned to the given institution, over the state fiscal year

757 preceding the date on which the allocation fraction is
758 calculated. The numerical value of this factor is the fraction
759 that the hospital represents of the total number of full-time
760 equivalent trainees enrolled in accredited graduate programs,
761 where the total is computed for all state statutory teaching
762 hospitals.
763 2. The number of medical students enrolled in accredited
764 colleges of medicine and engaged in clinical activities,
765 including required clinical clerkships and clinical electives.
766 Full-time equivalents are computed using the fraction of the
767 year during which each trainee is primarily assigned to the
768 given institution, over the course of the state fiscal year
769 preceding the date on which the allocation fraction is
770 calculated. The numerical value of this factor is the fraction
771 that the given hospital represents of the total number of full-
772 time equivalent students enrolled in accredited colleges of
773 medicine, where the total is computed for all state statutory
774 teaching hospitals.
775
776 The primary factor for full-time equivalent trainees is computed
777 as the sum of these two components, divided by two.
778 (c) A service index that comprises three components:
779 1. The Agency for Health Care Administration Service
780 Index, computed by applying the standard Service Inventory
781 Scores established by the Agency for Health Care Administration
782 to services offered by the given hospital, as reported on
783 Worksheet A-2 for the last fiscal year reported to the agency
784 before the date on which the allocation fraction is calculated.

785 The numerical value of this factor is the fraction that the
786 given hospital represents of the total Agency for Health Care
787 Administration Service Index values, where the total is computed
788 for all state statutory teaching hospitals.
789 2. A volume-weighted service index, computed by applying
790 the standard Service Inventory Scores established by the Agency
791 for Health Care Administration to the volume of each service,
792 expressed in terms of the standard units of measure reported on
793 Worksheet A-2 for the last fiscal year reported to the agency
794 before the date on which the allocation factor is calculated.
795 The numerical value of this factor is the fraction that the
796 given hospital represents of the total volume-weighted service
797 index values, where the total is computed for all state
798 statutory teaching hospitals.
799 3. Total Medicaid payments to each hospital for direct
800 inpatient and outpatient services during the fiscal year
801 preceding the date on which the allocation factor is calculated.
802 This includes payments made to each hospital for such services
803 by Medicaid prepaid health plans, whether the plan was
804 administered by the hospital or not. The numerical value of this
805 factor is the fraction that each hospital represents of the
806 total of such Medicaid payments, where the total is computed for
807 all state statutory teaching hospitals.
808
809 The primary factor for the service index is computed as the sum
810 of these three components, divided by three.
811 (2) By October 1 of each year, the agency shall use the
812 following formula to calculate the maximum additional

813 disproportionate share payment for statutorily defined teaching
814 hospitals:
815
816 TAP = THAF x A
817
818 Where:
819 TAP = total additional payment.
820 THAF = teaching hospital allocation factor.
821 A = amount appropriated for a teaching hospital
822 disproportionate share program.
823 Section 17. Section 409.9117, Florida Statutes, is amended
824 to read:
825 409.9117 Primary care disproportionate share program.--For
826 the state fiscal year 2006-2007 ~~2005-2006~~, the agency shall not
827 distribute moneys under the primary care disproportionate share
828 program.
829 (1) If federal funds are available for disproportionate
830 share programs in addition to those otherwise provided by law,
831 there shall be created a primary care disproportionate share
832 program.
833 (2) The following formula shall be used by the agency to
834 calculate the total amount earned for hospitals that participate
835 in the primary care disproportionate share program:
836
837 TAE = HDSP/THDSP
838
839 Where:
840 TAE = total amount earned by a hospital participating in

841 the primary care disproportionate share program.
842 HDSP = the prior state fiscal year primary care
843 disproportionate share payment to the individual hospital.
844 THDSP = the prior state fiscal year total primary care
845 disproportionate share payments to all hospitals.
846 (3) The total additional payment for hospitals that
847 participate in the primary care disproportionate share program
848 shall be calculated by the agency as follows:
849
850 TAP = TAE x TA
851
852 Where:
853 TAP = total additional payment for a primary care hospital.
854 TAE = total amount earned by a primary care hospital.
855 TA = total appropriation for the primary care
856 disproportionate share program.
857 (4) In the establishment and funding of this program, the
858 agency shall use the following criteria in addition to those
859 specified in s. 409.911, payments may not be made to a hospital
860 unless the hospital agrees to:
861 (a) Cooperate with a Medicaid prepaid health plan, if one
862 exists in the community.
863 (b) Ensure the availability of primary and specialty care
864 physicians to Medicaid recipients who are not enrolled in a
865 prepaid capitated arrangement and who are in need of access to
866 such physicians.
867 (c) Coordinate and provide primary care services free of
868 charge, except copayments, to all persons with incomes up to 100

869 percent of the federal poverty level who are not otherwise
870 covered by Medicaid or another program administered by a
871 governmental entity, and to provide such services based on a
872 sliding fee scale to all persons with incomes up to 200 percent
873 of the federal poverty level who are not otherwise covered by
874 Medicaid or another program administered by a governmental
875 entity, except that eligibility may be limited to persons who
876 reside within a more limited area, as agreed to by the agency
877 and the hospital.
878 (d) Contract with any federally qualified health center,
879 if one exists within the agreed geopolitical boundaries,
880 concerning the provision of primary care services, in order to
881 guarantee delivery of services in a nonduplicative fashion, and
882 to provide for referral arrangements, privileges, and
883 admissions, as appropriate. The hospital shall agree to provide
884 at an onsite or offsite facility primary care services within 24
885 hours to which all Medicaid recipients and persons eligible
886 under this paragraph who do not require emergency room services
887 are referred during normal daylight hours.
888 (e) Cooperate with the agency, the county, and other
889 entities to ensure the provision of certain public health
890 services, case management, referral and acceptance of patients,
891 and sharing of epidemiological data, as the agency and the
892 hospital find mutually necessary and desirable to promote and
893 protect the public health within the agreed geopolitical
894 boundaries.
895 (f) In cooperation with the county in which the hospital
896 resides, develop a low-cost, outpatient, prepaid health care

897 program to persons who are not eligible for the Medicaid
898 program, and who reside within the area.
899 (g) Provide inpatient services to residents within the
900 area who are not eligible for Medicaid or Medicare, and who do
901 not have private health insurance, regardless of ability to pay,
902 on the basis of available space, except that nothing shall
903 prevent the hospital from establishing bill collection programs
904 based on ability to pay.
905 (h) Work with the Florida Healthy Kids Corporation, the
906 Florida Health Care Purchasing Cooperative, and business health
907 coalitions, as appropriate, to develop a feasibility study and
908 plan to provide a low-cost comprehensive health insurance plan
909 to persons who reside within the area and who do not have access
910 to such a plan.
911 (i) Work with public health officials and other experts to
912 provide community health education and prevention activities
913 designed to promote healthy lifestyles and appropriate use of
914 health services.
915 (j) Work with the local health council to develop a plan
916 for promoting access to affordable health care services for all
917 persons who reside within the area, including, but not limited
918 to, public health services, primary care services, inpatient
919 services, and affordable health insurance generally.
920
921 Any hospital that fails to comply with any of the provisions of
922 this subsection, or any other contractual condition, may not
923 receive payments under this section until full compliance is
924 achieved.

925 Section 18. Paragraph (a) of subsection (39) and
926 subsection (44) of section 409.912, Florida Statutes, are
927 amended to read:
928 409.912 Cost-effective purchasing of health care.--The
929 agency shall purchase goods and services for Medicaid recipients
930 in the most cost-effective manner consistent with the delivery
931 of quality medical care. To ensure that medical services are
932 effectively utilized, the agency may, in any case, require a
933 confirmation or second physician's opinion of the correct
934 diagnosis for purposes of authorizing future services under the
935 Medicaid program. This section does not restrict access to
936 emergency services or poststabilization care services as defined
937 in 42 C.F.R. part 438.114. Such confirmation or second opinion
938 shall be rendered in a manner approved by the agency. The agency
939 shall maximize the use of prepaid per capita and prepaid
940 aggregate fixed-sum basis services when appropriate and other
941 alternative service delivery and reimbursement methodologies,
942 including competitive bidding pursuant to s. 287.057, designed
943 to facilitate the cost-effective purchase of a case-managed
944 continuum of care. The agency shall also require providers to
945 minimize the exposure of recipients to the need for acute
946 inpatient, custodial, and other institutional care and the
947 inappropriate or unnecessary use of high-cost services. The
948 agency shall contract with a vendor to monitor and evaluate the
949 clinical practice patterns of providers in order to identify
950 trends that are outside the normal practice patterns of a
951 provider's professional peers or the national guidelines of a
952 provider's professional association. The vendor must be able to

953 provide information and counseling to a provider whose practice
954 patterns are outside the norms, in consultation with the agency,
955 to improve patient care and reduce inappropriate utilization.
956 The agency may mandate prior authorization, drug therapy
957 management, or disease management participation for certain
958 populations of Medicaid beneficiaries, certain drug classes, or
959 particular drugs to prevent fraud, abuse, overuse, and possible
960 dangerous drug interactions. The Pharmaceutical and Therapeutics
961 Committee shall make recommendations to the agency on drugs for
962 which prior authorization is required. The agency shall inform
963 the Pharmaceutical and Therapeutics Committee of its decisions
964 regarding drugs subject to prior authorization. The agency is
965 authorized to limit the entities it contracts with or enrolls as
966 Medicaid providers by developing a provider network through
967 provider credentialing. The agency may competitively bid single-
968 source-provider contracts if procurement of goods or services
969 results in demonstrated cost savings to the state without
970 limiting access to care. The agency may limit its network based
971 on the assessment of beneficiary access to care, provider
972 availability, provider quality standards, time and distance
973 standards for access to care, the cultural competence of the
974 provider network, demographic characteristics of Medicaid
975 beneficiaries, practice and provider-to-beneficiary standards,
976 appointment wait times, beneficiary use of services, provider
977 turnover, provider profiling, provider licensure history,
978 previous program integrity investigations and findings, peer
979 review, provider Medicaid policy and billing compliance records,
980 clinical and medical record audits, and other factors. Providers

981 shall not be entitled to enrollment in the Medicaid provider
982 network. The agency shall determine instances in which allowing
983 Medicaid beneficiaries to purchase durable medical equipment and
984 other goods is less expensive to the Medicaid program than long-
985 term rental of the equipment or goods. The agency may establish
986 rules to facilitate purchases in lieu of long-term rentals in
987 order to protect against fraud and abuse in the Medicaid program
988 as defined in s. 409.913. The agency may seek federal waivers
989 necessary to administer these policies.
990 (39)(a) The agency shall implement a Medicaid prescribed-
991 drug spending-control program that includes the following
992 components:
993 1. A Medicaid preferred drug list, which shall be a
994 listing of cost-effective therapeutic options recommended by the
995 Medicaid Pharmacy and Therapeutics Committee established
996 pursuant to s. 409.91195 and adopted by the agency for each
997 therapeutic class on the preferred drug list. At the discretion
998 of the committee, and when feasible, the preferred drug list
999 should include at least two products in a therapeutic class. The
1000 agency may post the preferred drug list and updates to the
1001 preferred drug list on an Internet website without following the
1002 rulemaking procedures of chapter 120. Antiretroviral agents are
1003 excluded from the preferred drug list. The agency shall also
1004 limit the amount of a prescribed drug dispensed to no more than
1005 a 34-day supply unless the drug products' smallest marketed
1006 package is greater than a 34-day supply, or the drug is
1007 determined by the agency to be a maintenance drug in which case
1008 a 100-day maximum supply may be authorized. The agency is

1009 authorized to seek any federal waivers necessary to implement
1010 these cost-control programs and to continue participation in the
1011 federal Medicaid rebate program, or alternatively to negotiate
1012 state-only manufacturer rebates. The agency may adopt rules to
1013 implement this subparagraph. The agency shall continue to
1014 provide unlimited contraceptive drugs and items. The agency must
1015 establish procedures to ensure that:
1016 a. There will be a response to a request for prior
1017 consultation by telephone or other telecommunication device
1018 within 24 hours after receipt of a request for prior
1019 consultation; and
1020 b. A 72-hour supply of the drug prescribed will be
1021 provided in an emergency or when the agency does not provide a
1022 response within 24 hours as required by sub-subparagraph a.
1023 2. Reimbursement to pharmacies for Medicaid prescribed
1024 drugs shall be set at the lesser of: the average wholesale price
1025 (AWP) minus 15.4 percent, the wholesaler acquisition cost (WAC)
1026 plus 5.75 percent, the federal upper limit (FUL), the state
1027 maximum allowable cost (SMAC), or the usual and customary (UAC)
1028 charge billed by the provider.
1029 3. The agency shall develop and implement a process for
1030 managing the drug therapies of Medicaid recipients who are using
1031 significant numbers of prescribed drugs each month. The
1032 management process may include, but is not limited to,
1033 comprehensive, physician-directed medical-record reviews, claims
1034 analyses, and case evaluations to determine the medical
1035 necessity and appropriateness of a patient's treatment plan and
1036 drug therapies. The agency may contract with a private

1037 organization to provide drug-program-management services. The
1038 Medicaid drug benefit management program shall include
1039 initiatives to manage drug therapies for HIV/AIDS patients,
1040 patients using 20 or more unique prescriptions in a 180-day
1041 period, and the top 1,000 patients in annual spending. The
1042 agency shall enroll any Medicaid recipient in the drug benefit
1043 management program if he or she meets the specifications of this
1044 provision and is not enrolled in a Medicaid health maintenance
1045 organization.
1046 4. The agency may limit the size of its pharmacy network
1047 based on need, competitive bidding, price negotiations,
1048 credentialing, or similar criteria. The agency shall give
1049 special consideration to rural areas in determining the size and
1050 location of pharmacies included in the Medicaid pharmacy
1051 network. A pharmacy credentialing process may include criteria
1052 such as a pharmacy's full-service status, location, size,
1053 patient educational programs, patient consultation, disease
1054 management services, and other characteristics. The agency may
1055 impose a moratorium on Medicaid pharmacy enrollment when it is
1056 determined that it has a sufficient number of Medicaid-
1057 participating providers. The agency must allow dispensing
1058 practitioners to participate as a part of the Medicaid pharmacy
1059 network regardless of the practitioner's proximity to any other
1060 entity that is dispensing prescription drugs under the Medicaid
1061 program. A dispensing practitioner must meet all credentialing
1062 requirements applicable to his or her practice, as determined by
1063 the agency.
1064 5. The agency shall develop and implement a program that

1065 requires Medicaid practitioners who prescribe drugs to use a
1066 counterfeit-proof prescription pad for Medicaid prescriptions.
1067 The agency shall require the use of standardized counterfeit-
1068 proof prescription pads by Medicaid-participating prescribers or
1069 prescribers who write prescriptions for Medicaid recipients. The
1070 agency may implement the program in targeted geographic areas or
1071 statewide.
1072 6. The agency may enter into arrangements that require
1073 manufacturers of generic drugs prescribed to Medicaid recipients
1074 to provide rebates of at least 15.1 percent of the average
1075 manufacturer price for the manufacturer's generic products.
1076 These arrangements shall require that if a generic-drug
1077 manufacturer pays federal rebates for Medicaid-reimbursed drugs
1078 at a level below 15.1 percent, the manufacturer must provide a
1079 supplemental rebate to the state in an amount necessary to
1080 achieve a 15.1-percent rebate level.
1081 7. The agency may establish a preferred drug list as
1082 described in this subsection, and, pursuant to the establishment
1083 of such preferred drug list, it is authorized to negotiate
1084 supplemental rebates from manufacturers that are in addition to
1085 those required by Title XIX of the Social Security Act and at no
1086 less than 14 percent of the average manufacturer price as
1087 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
1088 the federal or supplemental rebate, or both, equals or exceeds
1089 29 percent. There is no upper limit on the supplemental rebates
1090 the agency may negotiate. The agency may determine that specific
1091 products, brand-name or generic, are competitive at lower rebate
1092 percentages. Agreement to pay the minimum supplemental rebate

1093 percentage will guarantee a manufacturer that the Medicaid
1094 Pharmaceutical and Therapeutics Committee will consider a
1095 product for inclusion on the preferred drug list. However, a
1096 pharmaceutical manufacturer is not guaranteed placement on the
1097 preferred drug list by simply paying the minimum supplemental
1098 rebate. Agency decisions will be made on the clinical efficacy
1099 of a drug and recommendations of the Medicaid Pharmaceutical and
1100 Therapeutics Committee, as well as the price of competing
1101 products minus federal and state rebates. The agency is
1102 authorized to contract with an outside agency or contractor to
1103 conduct negotiations for supplemental rebates. For the purposes
1104 of this section, the term "supplemental rebates" means cash
1105 rebates. Effective July 1, 2004, value-added programs as a
1106 substitution for supplemental rebates are prohibited. The agency
1107 is authorized to seek any federal waivers to implement this
1108 initiative.
1109 8. The Agency for Health Care Administration shall expand
1110 home delivery of pharmacy products. To assist Medicaid patients
1111 in securing their prescriptions and reduce program costs, the
1112 agency shall expand its current mail-order-pharmacy diabetes-
1113 supply program to include all generic and brand-name drugs used
1114 by Medicaid patients with diabetes. Medicaid recipients in the
1115 current program may obtain nondiabetes drugs on a voluntary
1116 basis. This initiative is limited to the geographic area covered
1117 by the current contract. The agency may seek and implement any
1118 federal waivers necessary to implement this subparagraph.
1119 9. The agency shall limit to one dose per month any drug
1120 prescribed to treat erectile dysfunction.

1121 10.a. The agency may implement a Medicaid behavioral drug
1122 management system. The agency may contract with a vendor that
1123 has experience in operating behavioral drug management systems
1124 to implement this program. The agency is authorized to seek
1125 federal waivers to implement this program.
1126 b. The agency, in conjunction with the Department of
1127 Children and Family Services, may implement the Medicaid
1128 behavioral drug management system that is designed to improve
1129 the quality of care and behavioral health prescribing practices
1130 based on best practice guidelines, improve patient adherence to
1131 medication plans, reduce clinical risk, and lower prescribed
1132 drug costs and the rate of inappropriate spending on Medicaid
1133 behavioral drugs. The program may include the following
1134 elements:
1135 (I) Provide for the development and adoption of best
1136 practice guidelines for behavioral health-related drugs such as
1137 antipsychotics, antidepressants, and medications for treating
1138 bipolar disorders and other behavioral conditions; translate
1139 them into practice; review behavioral health prescribers and
1140 compare their prescribing patterns to a number of indicators
1141 that are based on national standards; and determine deviations
1142 from best practice guidelines.
1143 (II) Implement processes for providing feedback to and
1144 educating prescribers using best practice educational materials
1145 and peer-to-peer consultation.
1146 (III) Assess Medicaid beneficiaries who are outliers in
1147 their use of behavioral health drugs with regard to the numbers
1148 and types of drugs taken, drug dosages, combination drug

1149 therapies, and other indicators of improper use of behavioral
1150 health drugs.
1151 (IV) Alert prescribers to patients who fail to refill
1152 prescriptions in a timely fashion, are prescribed multiple same-
1153 class behavioral health drugs, and may have other potential
1154 medication problems.
1155 (V) Track spending trends for behavioral health drugs and
1156 deviation from best practice guidelines.
1157 (VI) Use educational and technological approaches to
1158 promote best practices, educate consumers, and train prescribers
1159 in the use of practice guidelines.
1160 (VII) Disseminate electronic and published materials.
1161 (VIII) Hold statewide and regional conferences.
1162 (IX) Implement a disease management program with a model
1163 quality-based medication component for severely mentally ill
1164 individuals and emotionally disturbed children who are high
1165 users of care.
1166 11.a. The agency shall implement a Medicaid prescription
1167 drug management system. The agency may contract with a vendor
1168 that has experience in operating prescription drug management
1169 systems in order to implement this system. Any management system
1170 that is implemented in accordance with this subparagraph must
1171 rely on cooperation between physicians and pharmacists to
1172 determine appropriate practice patterns and clinical guidelines
1173 to improve the prescribing, dispensing, and use of drugs in the
1174 Medicaid program. The agency may seek federal waivers to
1175 implement this program.
1176 b. The drug management system must be designed to improve

1177 the quality of care and prescribing practices based on best
1178 practice guidelines, improve patient adherence to medication
1179 plans, reduce clinical risk, and lower prescribed drug costs and
1180 the rate of inappropriate spending on Medicaid prescription
1181 drugs. The program must:
1182 (I) Provide for the development and adoption of best
1183 practice guidelines for the prescribing and use of drugs in the
1184 Medicaid program, including translating best practice guidelines
1185 into practice; reviewing prescriber patterns and comparing them
1186 to indicators that are based on national standards and practice
1187 patterns of clinical peers in their community, statewide, and
1188 nationally; and determine deviations from best practice
1189 guidelines.
1190 (II) Implement processes for providing feedback to and
1191 educating prescribers using best practice educational materials
1192 and peer-to-peer consultation.
1193 (III) Assess Medicaid recipients who are outliers in their
1194 use of a single or multiple prescription drugs with regard to
1195 the numbers and types of drugs taken, drug dosages, combination
1196 drug therapies, and other indicators of improper use of
1197 prescription drugs.
1198 (IV) Alert prescribers to patients who fail to refill
1199 prescriptions in a timely fashion, are prescribed multiple drugs
1200 that may be redundant or contraindicated, or may have other
1201 potential medication problems.
1202 (V) Track spending trends for prescription drugs and
1203 deviation from best practice guidelines.
1204 (VI) Use educational and technological approaches to

1205 promote best practices, educate consumers, and train prescribers
1206 in the use of practice guidelines.
1207 (VII) Disseminate electronic and published materials.
1208 (VIII) Hold statewide and regional conferences.
1209 (IX) Implement disease management programs in cooperation
1210 with physicians and pharmacists, along with a model quality-
1211 based medication component for individuals having chronic
1212 medical conditions.
1213 12. The agency is authorized to contract for drug rebate
1214 administration, including, but not limited to, calculating
1215 rebate amounts, invoicing manufacturers, negotiating disputes
1216 with manufacturers, and maintaining a database of rebate
1217 collections.
1218 13. The agency may specify the preferred daily dosing form
1219 or strength for the purpose of promoting best practices with
1220 regard to the prescribing of certain drugs as specified in the
1221 General Appropriations Act and ensuring cost-effective
1222 prescribing practices.
1223 14. The agency may require prior authorization for
1224 Medicaid-covered prescribed drugs. The agency may, but is not
1225 required to, prior-authorize the use of a product:
1226 a. For an indication not approved in labeling;
1227 b. To comply with certain clinical guidelines; or
1228 c. If the product has the potential for overuse, misuse,
1229 or abuse.
1230
1231 The agency may require the prescribing professional to provide
1232 information about the rationale and supporting medical evidence

1233 for the use of a drug. The agency may post prior authorization
1234 criteria and protocol and updates to the list of drugs that are
1235 subject to prior authorization on an Internet website without
1236 amending its rule or engaging in additional rulemaking.
1237 15. The agency, in conjunction with the Pharmaceutical and
1238 Therapeutics Committee, may require age-related prior
1239 authorizations for certain prescribed drugs. The agency may
1240 preauthorize the use of a drug for a recipient who may not meet
1241 the age requirement or may exceed the length of therapy for use
1242 of this product as recommended by the manufacturer and approved
1243 by the Food and Drug Administration. Prior authorization may
1244 require the prescribing professional to provide information
1245 about the rationale and supporting medical evidence for the use
1246 of a drug.
1247 16. The agency shall implement a step-therapy prior
1248 authorization approval process for medications excluded from the
1249 preferred drug list. Medications listed on the preferred drug
1250 list must be used within the previous 12 months prior to the
1251 alternative medications that are not listed. The step-therapy
1252 prior authorization may require the prescriber to use the
1253 medications of a similar drug class or for a similar medical
1254 indication unless contraindicated in the Food and Drug
1255 Administration labeling. The trial period between the specified
1256 steps may vary according to the medical indication. The step-
1257 therapy approval process shall be developed in accordance with
1258 the committee as stated in s. 409.91195(7) and (8). A drug
1259 product may be approved without meeting the step-therapy prior
1260 authorization criteria if the prescribing physician provides the

1261 agency with additional written medical or clinical documentation
1262 that the product is medically necessary because:
1263 a. There is not a drug on the preferred drug list to treat
1264 the disease or medical condition which is an acceptable clinical
1265 alternative;
1266 b. The alternatives have been ineffective in the treatment
1267 of the beneficiary's disease; or
1268 c. Based on historic evidence and known characteristics of
1269 the patient and the drug, the drug is likely to be ineffective,
1270 or the number of doses have been ineffective.
1271
1272 The agency shall work with the physician to determine the best
1273 alternative for the patient. The agency may adopt rules waiving
1274 the requirements for written clinical documentation for specific
1275 drugs in limited clinical situations.
1276 17. The agency shall implement a return and reuse program
1277 for drugs dispensed by pharmacies to institutional recipients,
1278 which includes payment of a $5 restocking fee for the
1279 implementation and operation of the program. The return and
1280 reuse program shall be implemented electronically and in a
1281 manner that promotes efficiency. The program must permit a
1282 pharmacy to exclude drugs from the program if it is not
1283 practical or cost-effective for the drug to be included and must
1284 provide for the return to inventory of drugs that cannot be
1285 credited or returned in a cost-effective manner. The agency
1286 shall determine if the program has reduced the amount of
1287 Medicaid prescription drugs which are destroyed on an annual
1288 basis and if there are additional ways to ensure more

1289 prescription drugs are not destroyed which could safely be
1290 reused. The agency's conclusion and recommendations shall be
1291 reported to the Legislature by December 1, 2005.
1292 (44) The Agency for Health Care Administration shall
1293 ensure that any Medicaid managed care plan as defined in s.
1294 409.9122(2)(f)~~(h)~~, whether paid on a capitated basis or a shared
1295 savings basis, is cost-effective. For purposes of this
1296 subsection, the term "cost-effective" means that a network's
1297 per-member, per-month costs to the state, including, but not
1298 limited to, fee-for-service costs, administrative costs, and
1299 case-management fees, if any, must be no greater than the
1300 state's costs associated with contracts for Medicaid services
1301 established under subsection (3), which may ~~shall~~ be ~~actuarially~~
1302 adjusted for health status ~~case mix, model, and service area~~.
1303 The agency shall conduct actuarially sound adjustments for
1304 health status ~~audits adjusted for case mix and model~~ in order to
1305 ensure such cost-effectiveness and shall publish the ~~audit~~
1306 results on its Internet website and submit the ~~audit~~ results
1307 annually to the Governor, the President of the Senate, and the
1308 Speaker of the House of Representatives no later than December
1309 31 of each year. Contracts established pursuant to this
1310 subsection which are not cost-effective may not be renewed.
1311 Section 19. Paragraphs (f) and (k) of subsection (2) of
1312 section 409.9122, Florida Statutes, are amended to read:
1313 409.9122 Mandatory Medicaid managed care enrollment;
1314 programs and procedures.--
1315 (2)
1316 (f) When a Medicaid recipient does not choose a managed

1317 care plan or MediPass provider, the agency shall assign the
1318 Medicaid recipient to a managed care plan or MediPass provider.
1319 Medicaid recipients who are subject to mandatory assignment but
1320 who fail to make a choice shall be assigned to managed care
1321 plans until an enrollment of 35 ~~40~~ percent in MediPass and 65 ~~60~~
1322 percent in managed care plans, of all those eligible to choose
1323 managed care, is achieved. Once this enrollment is achieved, the
1324 assignments shall be divided in order to maintain an enrollment
1325 in MediPass and managed care plans which is in a 35 ~~40~~ percent
1326 and 65 ~~60~~ percent proportion, respectively. Thereafter,
1327 assignment of Medicaid recipients who fail to make a choice
1328 shall be based proportionally on the preferences of recipients
1329 who have made a choice in the previous period. Such proportions
1330 shall be revised at least quarterly to reflect an update of the
1331 preferences of Medicaid recipients. The agency shall
1332 disproportionately assign Medicaid-eligible recipients who are
1333 required to but have failed to make a choice of managed care
1334 plan or MediPass, including children, and who are to be assigned
1335 to the MediPass program to children's networks as described in
1336 s. 409.912(4)(g), Children's Medical Services Network as defined
1337 in s. 391.021, exclusive provider organizations, provider
1338 service networks, minority physician networks, and pediatric
1339 emergency department diversion programs authorized by this
1340 chapter or the General Appropriations Act, in such manner as the
1341 agency deems appropriate, until the agency has determined that
1342 the networks and programs have sufficient numbers to be
1343 economically operated. For purposes of this paragraph, when
1344 referring to assignment, the term "managed care plans" includes

1345 health maintenance organizations, exclusive provider
1346 organizations, provider service networks, minority physician
1347 networks, Children's Medical Services Network, and pediatric
1348 emergency department diversion programs authorized by this
1349 chapter or the General Appropriations Act. When making
1350 assignments, the agency shall take into account the following
1351 criteria:
1352 1. A managed care plan has sufficient network capacity to
1353 meet the need of members.
1354 2. The managed care plan or MediPass has previously
1355 enrolled the recipient as a member, or one of the managed care
1356 plan's primary care providers or MediPass providers has
1357 previously provided health care to the recipient.
1358 3. The agency has knowledge that the member has previously
1359 expressed a preference for a particular managed care plan or
1360 MediPass provider as indicated by Medicaid fee-for-service
1361 claims data, but has failed to make a choice.
1362 4. The managed care plan's or MediPass primary care
1363 providers are geographically accessible to the recipient's
1364 residence.
1365 (k) When a Medicaid recipient does not choose a managed
1366 care plan or MediPass provider, the agency shall assign the
1367 Medicaid recipient to a managed care plan, except in those
1368 counties in which there are fewer than two managed care plans
1369 accepting Medicaid enrollees, in which case assignment shall be
1370 to a managed care plan or a MediPass provider. Medicaid
1371 recipients in counties with fewer than two managed care plans
1372 accepting Medicaid enrollees who are subject to mandatory

1373 assignment but who fail to make a choice shall be assigned to
1374 managed care plans until an enrollment of 35 ~~40~~ percent in
1375 MediPass and 65 ~~60~~ percent in managed care plans, of all those
1376 eligible to choose managed care, is achieved. Once that
1377 enrollment is achieved, the assignments shall be divided in
1378 order to maintain an enrollment in MediPass and managed care
1379 plans which is in a 35 ~~40~~ percent and 65 ~~60~~ percent proportion,
1380 respectively. In service areas 1 and 6 of the Agency for Health
1381 Care Administration where the agency is contracting for the
1382 provision of comprehensive behavioral health services through a
1383 capitated prepaid arrangement, recipients who fail to make a
1384 choice shall be assigned equally to MediPass or a managed care
1385 plan. For purposes of this paragraph, when referring to
1386 assignment, the term "managed care plans" includes exclusive
1387 provider organizations, provider service networks, Children's
1388 Medical Services Network, minority physician networks, and
1389 pediatric emergency department diversion programs authorized by
1390 this chapter or the General Appropriations Act. When making
1391 assignments, the agency shall take into account the following
1392 criteria:
1393 1. A managed care plan has sufficient network capacity to
1394 meet the need of members.
1395 2. The managed care plan or MediPass has previously
1396 enrolled the recipient as a member, or one of the managed care
1397 plan's primary care providers or MediPass providers has
1398 previously provided health care to the recipient.
1399 3. The agency has knowledge that the member has previously
1400 expressed a preference for a particular managed care plan or

1401 MediPass provider as indicated by Medicaid fee-for-service
1402 claims data, but has failed to make a choice.
1403 4. The managed care plan's or MediPass primary care
1404 providers are geographically accessible to the recipient's
1405 residence.
1406 5. The agency has authority to make mandatory assignments
1407 based on quality of service and performance of managed care
1408 plans.
1409 Section 20. Section 409.9301, Florida Statutes, is created
1410 to read:
1411 409.9301 Pharmaceutical expense assistance.--
1412 (1) PROGRAM ESTABLISHED.--A program is established in the
1413 Agency for Health Care Administration to provide pharmaceutical
1414 expense assistance to individuals diagnosed with cancer or
1415 individuals who have received organ transplants who were
1416 medically needy recipients prior to January 1, 2006.
1417 (2) ELIGIBILITY.--Eligibility for the program is limited
1418 to an individual who:
1419 (a) Is a resident of this state;
1420 (b) Was a Medicaid recipient under the Florida Medicaid
1421 medically needy program prior to January 1, 2006;
1422 (c) Is eligible for Medicare;
1423 (d) Is a cancer patient or an organ transplant recipient;
1424 and
1425 (e) Requests to be enrolled in the program.
1426 (3) BENEFITS.--Subject to an appropriation in the General
1427 Appropriations Act and the availability of funds, the Agency for
1428 Health Care Administration shall pay, using Medicaid payment

1429 policies, the Medicare Part-B prescription drug coinsurance and
1430 deductibles for Medicare Part-B medications that treat eligible
1431 cancer and organ transplant patients.
1432 (4) ADMINISTRATION.--The pharmaceutical expense assistance
1433 program shall be administered by the agency, in collaboration
1434 with the Department of Elderly Affairs and the Department of
1435 Children and Family Services.
1436 (a) The agency may adopt rules pursuant to ss. 120.536(1)
1437 and 120.54 to implement the provisions of this section.
1438 (b) By January 1 of each year, the agency shall report to
1439 the Legislature on the operation of the program. The report
1440 shall include information on the number of individuals served,
1441 use rates, and expenditures under the program.
1442 (5) NONENTITLEMENT.--The pharmaceutical expense assistance
1443 program established by this section is not an entitlement. The
1444 agency may develop a waiting list based on application dates to
1445 use in enrolling individuals when funds become available for
1446 unfilled enrollment slots.
1447 Section 21. Subsection (17) is added to section 430.04,
1448 Florida Statutes, to read:
1449 430.04 Duties and responsibilities of the Department of
1450 Elderly Affairs.--The Department of Elderly Affairs shall:
1451 (17) Be designated as a state agency that is eligible to
1452 receive federal funds for adults who are eligible for assistance
1453 through the portion of the federal Child and Adult Care Food
1454 Program for adults, which is referred to as the Adult Care Food
1455 Program, and that is responsible for establishing and
1456 administering the program. The purpose of the Adult Care Food

1457 Program is to provide nutritious and wholesome meals and snacks
1458 for adults in nonresidential day care centers or residential
1459 treatment facilities. To ensure the quality and integrity of the
1460 program, the department shall develop standards and procedures
1461 that govern sponsoring organizations and adult day care centers.
1462 The department shall follow federal requirements and may adopt
1463 any rules necessary pursuant to ss. 120.536(1) and 120.54 for
1464 the implementation of the Adult Care Food Program. With respect
1465 to the Adult Care Food Program, the department shall adopt rules
1466 pursuant to ss. 120.536(1) and 120.54 that implement relevant
1467 federal regulations, including 7 C.F.R. part 226. The rules may
1468 address, at a minimum, the program requirements and procedures
1469 identified in this subsection.
1470 Section 22. Subsection (5) of section 430.705, Florida
1471 Statutes, is amended to read:
1472 430.705 Implementation of the long-term care community
1473 diversion pilot projects.--
1474 (5) A prospective participant who applies for the long-
1475 term care community diversion pilot project and is determined by
1476 the Comprehensive Assessment Review and Evaluation for Long-Term
1477 Care Services (CARES) Program within the Department of Elderly
1478 Affairs to be medically eligible, but has not been determined
1479 financially eligible by the Department of Children and Family
1480 Services, shall be designated "Medicaid Pending." CARES shall
1481 determine each applicant's eligibility within 22 days after
1482 receiving the application. Contractors may elect to provide
1483 services to Medicaid Pending individuals until their financial
1484 eligibility is determined. If the individual is determined

1485 financially eligible, the agency shall pay the contractor that
1486 provided the services a capitated rate retroactive to the first
1487 of the month following the CARES eligibility determination. If
1488 the individual is not financially eligible for Medicaid, the
1489 contractor may terminate services and seek reimbursement from
1490 the individual. ~~In order to achieve rapid enrollment into the~~
1491 ~~program and efficient diversion of applicants from nursing home~~
1492 ~~care, the department and the agency shall allow enrollment of~~
1493 ~~Medicaid beneficiaries on the date that eligibility for the~~
1494 ~~community diversion pilot project is approved. The provider~~
1495 ~~shall receive a prorated capitated rate for those enrollees who~~
1496 ~~are enrolled after the first of each month.~~
1497 Section 23. Paragraph (b) of subsection (5) of section
1498 624.91, Florida Statutes, is amended to read:
1499 624.91 The Florida Healthy Kids Corporation Act.--
1500 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.--
1501 (b) The Florida Healthy Kids Corporation shall:
1502 1. Arrange for the collection of any family, local
1503 contributions, or employer payment or premium, in an amount to
1504 be determined by the board of directors, to provide for payment
1505 of premiums for comprehensive insurance coverage and for the
1506 actual or estimated administrative expenses.
1507 2. Arrange for the collection of any voluntary
1508 contributions to provide for payment of premiums for children
1509 who are not eligible for medical assistance under Title XXI of
1510 the Social Security Act. ~~Each fiscal year, the corporation shall~~
1511 ~~establish a local match policy for the enrollment of non-Title-~~
1512 ~~XXI-eligible children in the Healthy Kids program. By May 1 of~~

1513 ~~each year, the corporation shall provide written notification of~~
1514 ~~the amount to be remitted to the corporation for the following~~
1515 ~~fiscal year under that policy. Local match sources may include,~~
1516 ~~but are not limited to, funds provided by municipalities,~~
1517 ~~counties, school boards, hospitals, health care providers,~~
1518 ~~charitable organizations, special taxing districts, and private~~
1519 ~~organizations. The minimum local match cash contributions~~
1520 ~~required each fiscal year and local match credits shall be~~
1521 ~~determined by the General Appropriations Act. The corporation~~
1522 ~~shall calculate a county's local match rate based upon that~~
1523 ~~county's percentage of the state's total non-Title XXI~~
1524 ~~expenditures as reported in the corporation's most recently~~
1525 ~~audited financial statement. In awarding the local match~~
1526 ~~credits, the corporation may consider factors including, but not~~
1527 ~~limited to, population density, per capita income, and existing~~
1528 ~~child-health-related expenditures and services.~~
1529 3. Subject to the provisions of s. 409.8134, accept
1530 voluntary supplemental local match contributions that comply
1531 with the requirements of Title XXI of the Social Security Act
1532 for the purpose of providing additional coverage in contributing
1533 counties under Title XXI.
1534 4. Establish the administrative and accounting procedures
1535 for the operation of the corporation.
1536 5. Establish, with consultation from appropriate
1537 professional organizations, standards for preventive health
1538 services and providers and comprehensive insurance benefits
1539 appropriate to children, provided that such standards for rural
1540 areas shall not limit primary care providers to board-certified

1541 pediatricians.
1542 6. Determine eligibility for children seeking to
1543 participate in the Title XXI-funded components of the Florida
1544 KidCare program consistent with the requirements specified in s.
1545 409.814, as well as the non-Title-XXI-eligible children as
1546 provided in subsection (3).
1547 7. Establish procedures under which providers of local
1548 match to, applicants to and participants in the program may have
1549 grievances reviewed by an impartial body and reported to the
1550 board of directors of the corporation.
1551 8. Establish participation criteria and, if appropriate,
1552 contract with an authorized insurer, health maintenance
1553 organization, or third-party administrator to provide
1554 administrative services to the corporation.
1555 9. Establish enrollment criteria which shall include
1556 penalties or waiting periods of not fewer than 60 days for
1557 reinstatement of coverage upon voluntary cancellation for
1558 nonpayment of family premiums.
1559 10. Contract with authorized insurers or any provider of
1560 health care services, meeting standards established by the
1561 corporation, for the provision of comprehensive insurance
1562 coverage to participants. Such standards shall include criteria
1563 under which the corporation may contract with more than one
1564 provider of health care services in program sites. Health plans
1565 shall be selected through a competitive bid process. The Florida
1566 Healthy Kids Corporation shall purchase goods and services in
1567 the most cost-effective manner consistent with the delivery of
1568 quality medical care. The maximum administrative cost for a

1569 Florida Healthy Kids Corporation contract shall be 15 percent.
1570 For health care contracts, the minimum medical loss ratio for a
1571 Florida Healthy Kids Corporation contract shall be 85 percent.
1572 For dental contracts, the remaining compensation to be paid to
1573 the authorized insurer or provider under a Florida Healthy Kids
1574 Corporation contract shall be no less than an amount which is 85
1575 percent of premium; to the extent any contract provision does
1576 not provide for this minimum compensation, this section shall
1577 prevail. The health plan selection criteria and scoring system,
1578 and the scoring results, shall be available upon request for
1579 inspection after the bids have been awarded.
1580 11. Establish disenrollment criteria in the event local
1581 matching funds are insufficient to cover enrollments.
1582 12. Develop and implement a plan to publicize the Florida
1583 Healthy Kids Corporation, the eligibility requirements of the
1584 program, and the procedures for enrollment in the program and to
1585 maintain public awareness of the corporation and the program.
1586 13. Secure staff necessary to properly administer the
1587 corporation. Staff costs shall be funded from state and local
1588 matching funds and such other private or public funds as become
1589 available. The board of directors shall determine the number of
1590 staff members necessary to administer the corporation.
1591 14. Provide a report annually to the Governor, Chief
1592 Financial Officer, Commissioner of Education, Senate President,
1593 Speaker of the House of Representatives, and Minority Leaders of
1594 the Senate and the House of Representatives.
1595 15. Establish benefit packages which conform to the
1596 provisions of the Florida KidCare program, as created in ss.

1597 409.810-409.820.
1598 Section 24. The Office of Program Policy Analysis and
1599 Government Accountability shall review the functions currently
1600 performed by the Comprehensive Assessment Review and Evaluation
1601 for Long-Term Care Services (CARES) Program within the
1602 Department of Elderly Affairs. The Office of Program Policy
1603 Analysis and Government Accountability shall identify the
1604 factors affecting the time currently required for CARES staff to
1605 assess an individual's eligibility for long-term care services.
1606 As part of this study, the Office of Program Policy Analysis and
1607 Government Accountability shall also examine circumstances that
1608 could delay an individual's placement into the long-term care
1609 community diversion pilot project. The Office of Program Policy
1610 Analysis and Government Accountability shall report its findings
1611 to the President of the Senate and the Speaker of the House of
1612 Representatives by February 1, 2007.
1613 Section 25. Section 409.8201, Florida Statutes, is
1614 repealed.
1615 Section 26. This act shall take effect July 1, 2006.