A bill to be entitled

An act relating to health care; amending s. 400.23, F.S.; delaying the effective date of certain requirements concerning hours of direct care per resident for nursing home facilities; amending s. 409.904, F.S.; revising requirements for certain optional payments under the Medicaid program; amending s. 409.906, F.S.; deleting provisions authorizing payment for adult dental services; revising requirements for hearing and visual services to limit such services to persons younger than 21 years of age; amending s. 409.908, F.S., relating to reimbursement of Medicaid providers; conforming a cross-reference; amending s. 409.9081, F.S.; providing a copayment under the Medicaid program for certain nonemergency hospital visits; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to establish certain protocols for categories of drugs; removing certain requirements for prior authorization for nursing home residents and institutionalized adults; prohibiting value-added rebates to a pharmaceutical manufacturer; deleting provisions authorizing certain benefits in conjunction with supplemental rebates; amending s. 409.9122, F.S.; revising the percentage of Medicaid recipients required to be enrolled in managed care; amending s. 409.915, F.S.; increasing the

requirements for county contributions to Medicaid; amending s. 409.815, F.S., relating to benefits coverage; specifying a maximum annual benefit for children's dental services; revising requirements for the Agency for Health Care Administration in distributing moneys under the regular disproportionate share program for the 2003-2004 fiscal year; providing legislative findings; providing a contingency with respect to specified provisions of the act taking effect; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

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

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

(3)(a) The agency shall adopt rules providing for the minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning January 1, 2003, and increasing to 2.9 hours of direct care per resident per day beginning July ~~January~~ 1, 2004. Beginning January 1, 2002, no facility shall staff below one certified nursing assistant per 20 residents, and a minimum licensed nursing staffing of 1.0 hour of direct resident care per resident per day but never below one

licensed nurse per 40 residents. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants only if they provide nursing assistance services to residents on a full-time basis. Each nursing home must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses so recognized are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted towards the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and shall not also be counted towards the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

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

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related

services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(2) ~~A caretaker relative or parent,~~A pregnant woman, a child under age 19 who would otherwise qualify for Florida Kidcare Medicaid, or a child up to age 21 who would otherwise qualify under s. 409.903(1), ~~a person age 65 or over, or a blind or disabled person,~~who would otherwise be eligible for Florida Medicaid, except that the income or assets of such ~~family or~~ person exceed established limitations. For a ~~family or~~ person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. Expenses used to meet spend-down liability are not reimbursable by Medicaid. Effective May 1, 2003, when determining the eligibility of a pregnant woman or~~,~~a child, ~~or an aged, blind, or disabled individual,~~$270 shall be deducted from the countable income of the filing unit. ~~When determining the eligibility of the parent or caretaker relative as defined by Title XIX of the Social Security Act, the additional income disregard of $270 does not apply.~~A ~~family or~~ person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 3. Section 409.906, Florida Statutes, is amended to read:

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

~~(1) ADULT DENTAL SERVICES.--The agency may pay for medically necessary, emergency dental procedures to alleviate pain or infection. Emergency dental care shall be limited to emergency oral examinations, necessary radiographs, extractions, and incision and drainage of abscess, for a recipient who is age 21 or older. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:~~

~~(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.~~

~~(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.~~

~~(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.~~

~~(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.~~

(1)~~(2)~~ ADULT HEALTH SCREENING SERVICES.--The agency may pay for an annual routine physical examination, conducted by or under the direction of a licensed physician, for a recipient age 21 or older, without regard to medical necessity, in order to detect and prevent disease, disability, or other health condition or its progression.

(2)~~(3)~~ AMBULATORY SURGICAL CENTER SERVICES.--The agency may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395, by or under the direction of a licensed physician or dentist.

(3)~~(4)~~ BIRTH CENTER SERVICES.--The agency may pay for examinations and delivery, recovery, and newborn assessment, and related services, provided in a licensed birth center staffed with licensed physicians, certified nurse midwives, and midwives licensed in accordance with chapter 467, to a

recipient expected to experience a low-risk pregnancy and delivery.

(4)~~(5)~~ CASE MANAGEMENT SERVICES.--The agency may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, for which funding has been provided and which are rendered pursuant to federal guidelines. The agency is authorized to limit reimbursement for targeted case management services in order to comply with any limitations or directions provided for in the General Appropriations Act. Notwithstanding s. 216.292, the Department of Children and Family Services may transfer general funds to the Agency for Health Care Administration to fund state match requirements exceeding the amount specified in the General Appropriations Act for targeted case management services.

(5)~~(6)~~ CHILDREN'S DENTAL SERVICES.--The agency may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program

specifications as a county health department clinic services provider.

(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

(6)~~(7)~~ CHIROPRACTIC SERVICES.--The agency may pay for manual manipulation of the spine and initial services, screening, and X rays provided to a recipient by a licensed chiropractic physician.

(7)~~(8)~~ COMMUNITY MENTAL HEALTH SERVICES.--

(a) The agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider under contract with the agency or the Department of Children and Family Services to provide such services. Those services which are psychiatric in nature shall be rendered or recommended by a psychiatrist, and those services which are medical in nature shall be rendered or recommended by a physician or psychiatrist. The agency must develop a provider enrollment process for community mental health providers which bases provider enrollment on an assessment of service need. The provider enrollment process shall be designed to control costs, prevent fraud and abuse, consider provider expertise and capacity, and assess provider success in managing utilization of care and measuring treatment outcomes.

Providers will be selected through a competitive procurement or selective contracting process. In addition to other community mental health providers, the agency shall consider for enrollment mental health programs licensed under chapter 395 and group practices licensed under chapter 458, chapter 459, chapter 490, or chapter 491. The agency is also authorized to continue operation of its behavioral health utilization management program and may develop new services if these actions are necessary to ensure savings from the implementation of the utilization management system. The agency shall coordinate the implementation of this enrollment process with the Department of Children and Family Services and the Department of Juvenile Justice. The agency is authorized to utilize diagnostic criteria in setting reimbursement rates, to preauthorize certain high-cost or highly utilized services, to limit or eliminate coverage for certain services, or to make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(b) The agency is authorized to implement reimbursement and use management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization of treatment and service plans; prior authorization of services; enhanced use review programs for highly used services; and limits on services for those determined to be abusing their benefit coverages.

(8)~~(9)~~ DIALYSIS FACILITY SERVICES.--Subject to specific appropriations being provided for this purpose, the agency may pay a dialysis facility that is approved as a dialysis facility in accordance with Title XVIII of the Social

Security Act, for dialysis services that are provided to a Medicaid recipient under the direction of a physician licensed to practice medicine or osteopathic medicine in this state, including dialysis services provided in the recipient's home by a hospital-based or freestanding dialysis facility.

(9)~~(10)~~ DURABLE MEDICAL EQUIPMENT.--The agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary.

(10)~~(11)~~ HEALTHY START SERVICES.--The agency may pay for a continuum of risk-appropriate medical and psychosocial services for the Healthy Start program in accordance with a federal waiver. The agency may not implement the federal waiver unless the waiver permits the state to limit enrollment or the amount, duration, and scope of services to ensure that expenditures will not exceed funds appropriated by the Legislature or available from local sources. If the Health Care Financing Administration does not approve a federal waiver for Healthy Start services, the agency, in consultation with the Department of Health and the Florida Association of Healthy Start Coalitions, is authorized to establish a Medicaid certified-match program for Healthy Start services. Participation in the Healthy Start certified-match program shall be voluntary, and reimbursement shall be limited to the federal Medicaid share to Medicaid-enrolled Healthy Start coalitions for services provided to Medicaid recipients. The agency shall take no action to implement a certified-match program without ensuring that the amendment and review requirements of ss. 216.177 and 216.181 have been met.

(11)~~(12)~~ CHILDREN'S HEARING SERVICES.--The agency may pay for hearing and related services, including hearing

evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient younger than 21 years of age by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(12)~~(13)~~ HOME AND COMMUNITY-BASED SERVICES.--The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program. The agency may limit or eliminate coverage for certain Project AIDS Care Waiver services, preauthorize high-cost or highly utilized services, or make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(13)~~(14)~~ HOSPICE CARE SERVICES.--The agency may pay for all reasonable and necessary services for the palliation or management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under part VI of chapter 400 and meets Medicare certification requirements.

(14)~~(15)~~ INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED SERVICES.--The agency may pay for health-related care and services provided on a 24-hour-a-day basis by a facility licensed and certified as a Medicaid Intermediate Care Facility for the Developmentally Disabled, for a recipient who needs such care because of a developmental disability.

(15)~~(16)~~ INTERMEDIATE CARE SERVICES.--The agency may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part II of chapter 400, if the services are ordered by and provided under the direction of a physician.

(16)~~(17)~~ OPTOMETRIC SERVICES.--The agency may pay for services provided to a recipient, including examination, diagnosis, treatment, and management, related to ocular pathology, if the services are provided by a licensed optometrist or physician.

(17)~~(18)~~ PHYSICIAN ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by a physician assistant licensed under s. 458.347 or s. 459.022. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

(18)~~(19)~~ PODIATRIC SERVICES.--The agency may pay for services, including diagnosis and medical, surgical, palliative, and mechanical treatment, related to ailments of the human foot and lower leg, if provided to a recipient by a podiatric physician licensed under state law.

(19)~~(20)~~ PRESCRIBED DRUG SERVICES.--The agency may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

(20)~~(21)~~ REGISTERED NURSE FIRST ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by a registered nurse first assistant as described in s. 464.027. Reimbursement for such services may not be less than 80 percent of the reimbursement that would be paid to a physician providing the same services.

(21)~~(22)~~ STATE HOSPITAL SERVICES.--The agency may pay for all-inclusive psychiatric inpatient hospital care provided to a recipient age 65 or older in a state mental hospital.

(22)~~(23)~~ CHILDREN'S VISUAL SERVICES.--The agency may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient younger than 21 years of age, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

(23)~~(24)~~ CHILD-WELFARE-TARGETED CASE MANAGEMENT.--The Agency for Health Care Administration, in consultation with the Department of Children and Family Services, may establish a targeted case-management project in those counties identified by the Department of Children and Family Services and for all counties with a community-based child welfare project, as authorized under s. 409.1671, which have been specifically approved by the department. Results of targeted case management projects shall be reported to the Social Services Estimating Conference established under s. 216.136. The covered group of individuals who are eligible to receive targeted case management include children who are eligible for Medicaid; who are between the ages of birth through 21; and who are under protective supervision or postplacement supervision, under foster-care supervision, or in shelter care or foster care. The number of individuals who are eligible to receive targeted case management shall be limited to the number for whom the Department of Children and Family Services has available matching funds to cover the costs. The general revenue funds required to match the funds for services provided by the community-based child welfare projects are limited to funds available for services described under s. 409.1671. The Department of Children and Family Services may transfer the general revenue matching funds as billed by the Agency for Health Care Administration.

(24)~~(25)~~ ASSISTIVE-CARE SERVICES.--The agency may pay for assistive-care services provided to recipients with functional or cognitive impairments residing in assisted living facilities, adult family-care homes, or residential treatment facilities. These services may include health support, assistance with the activities of daily living and the instrumental acts of daily living, assistance with medication administration, and arrangements for health care.

Section 4. Subsection (20) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be affected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions

provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(20) A renal dialysis facility that provides dialysis services under s. 409.906(8)~~s. 409.906(9)~~must be reimbursed the lesser of the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less.

Section 5. Subsection (1) of section 409.9081, Florida Statutes, is amended to read:

409.9081 Copayments.--

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

(a) Hospital outpatient services: up to $3 for each hospital outpatient visit.

(b) Physician services: up to $2 copayment for each visit with a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463.

(c) Hospital emergency department visits for nonemergency care: $15 for each emergency department visit.

Section 6. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may establish prior authorization requirements for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. <u>The agency may also establish step-therapy protocols for the categories of drugs representing Cox II and proton pump inhibitor drugs.</u>The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization.

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

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

(3) The agency may contract with:

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

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the

department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance-abuse-treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid

recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance-abuse-treatment services.

2. By December 31, 2001, the agency shall contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Charlotte, Collier, DeSoto, Escambia, Glades, Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota, and Walton Counties. The agency may contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid arrangements in Alachua County. The agency may determine if Sarasota County shall be included as a separate catchment area or included in any other agency geographic area.

3. Children residing in a Department of Juvenile Justice residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan pursuant to this paragraph.

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

5. Traditional community mental health providers under contract with the Department of Children and Family Services

pursuant to part IV of chapter 394 and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

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

(d) No more than four provider service networks for demonstration projects to test Medicaid direct contracting. The demonstration projects may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. A demonstration project awarded

pursuant to this paragraph shall be for 4 years from the date of implementation.

(e) An entity that provides comprehensive behavioral health care services to certain Medicaid recipients through an administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services.

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

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

use of the children's networks rather than hospital emergency departments.

(h) An entity authorized in s. 430.205 to contract with the agency and the Department of Elderly Affairs to provide health care and social services on a prepaid or fixed-sum basis to elderly recipients. Such prepaid health care services entities are exempt from the provisions of part I of chapter 641 for the first 3 years of operation. An entity recognized under this paragraph that demonstrates to the satisfaction of the Department of Insurance that it is backed by the full faith and credit of one or more counties in which it operates may be exempted from s. 641.225.

(i) A Children's Medical Services network, as defined in s. 391.021.

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

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

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

(c) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;

(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and

that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

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

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

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

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

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

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Department of Insurance.

(6) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law.

(7) The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on

a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization.

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

(a) Fraud;

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

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

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(9) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the

Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

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

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

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

(11) The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

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

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

(b) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs.

(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the individual requires nursing facility care and that the individual cannot be safely served in community-based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program.

(d) By January 1 of each year, the agency shall submit a report to the Legislature and the Office of Long-Term-Care Policy describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

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

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

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

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

(b) The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste,

and abuse prevention and detection programs; and beneficiary case management programs.

1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The panel shall begin its work by August 1, 1999, regardless of the number of appointments made by that date. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization.

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

3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries inappropriately using their benefits, and other

steps that will eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

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

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

(15) An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency or the Department of Insurance, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues. As used in this subsection, the term "surplus" means the entity's total assets minus total liabilities. If an entity's surplus falls below an amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

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

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

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

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

(16)(a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in this state. The entity shall deposit into that account 5 percent of the capitation payments made by the agency each month until a maximum total of 2 percent of the total current contract amount is reached. The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the entity and two representatives of the agency. If the agency finds that the entity is insolvent, the agency may draw upon the account solely with the two authorized signatures of representatives of the agency, and the funds may be disbursed to meet financial obligations incurred by the entity under the prepaid contract. If the contract is terminated, expired, or not continued, the account balance must be released by the agency to the entity upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

(b) The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance

that will protect enrollees if the entity becomes unable to meet its obligations.

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

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

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

(18) When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Department of Insurance pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger or acquisition if the contractor and the other entity have been in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase.

(19) Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid

recipients is prohibited from engaging in any of the following practices or activities:

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

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

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

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

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

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

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (21).

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

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and

supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

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

(21) A health maintenance organization or a person or entity exempt from chapter 641 that is under contract with the agency for the provision of health care services to Medicaid recipients may not use or distribute marketing materials used to solicit Medicaid recipients, unless such materials have been approved by the agency. The provisions of this subsection do not apply to general advertising and marketing materials used by a health maintenance organization to solicit both non-Medicaid subscribers and Medicaid recipients.

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

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

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

(25) The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality assurance reform initiative. The system shall include, but need not be limited to, the following:

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

1. Written quality assurance program descriptions.

2. Responsibilities of the governing body for monitoring, evaluating, and making improvements to care.

3. An active quality assurance committee.

4. Quality assurance program supervision.

5. Requiring the program to have adequate resources to effectively carry out its specified activities.

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

12. Accessibility and availability of medical records, as well as proper recordkeeping and process for record review.

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

16. Coordination of quality assurance activity with other management activity.

17. Delivering care to pregnant women and infants; to elderly and disabled recipients, especially those who are at risk of institutional placement; to persons with developmental disabilities; and to adults who have chronic, high-cost medical conditions.

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

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

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

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

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

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

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

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

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

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

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

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

(27) The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (18)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until

the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract.

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

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

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

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

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

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

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

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

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

(31) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata

basis if payment has been made for the enrollment month when disenrollment occurs.

(32) The agency and entities which contract with the agency to provide health care services to Medicaid recipients under this section or s. 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients.

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

(a) Healthy Start prenatal or infant screening.

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

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

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

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

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

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

(34) Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases

where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.

(35) The agency may seek and implement federal waivers necessary to provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, and durable medical equipment and supplies through competitive bidding pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid such services. The agency may exclude providers not selected through the bidding process from the Medicaid provider network.

(36) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory, diagnostic imaging, and specified home medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.

(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services must, at a minimum, meet the following criteria:

1. The entity must be licensed by the Department of Insurance under part II of chapter 641.

2. The entity must be experienced in providing outpatient specialty services.

3. The entity must demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.

4. The entity must demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients enrolled in the pilot managed care program to resolve complaints and grievances.

(b) The pilot managed care program shall operate for a period of 3 years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient specialty services to Medicaid recipients on a prepaid, capitated basis.

(c) The agency shall conduct a quality assurance review of the prepaid health clinic each year that the demonstration program is in effect. The prepaid health clinic is responsible for all expenses incurred by the agency in conducting a quality assurance review.

(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).

(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.

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

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

1. Medicaid prescribed-drug coverage for brand-name drugs for adult Medicaid recipients is limited to the dispensing of four brand-name drugs per month per recipient. Children are exempt from this restriction. Antiretroviral agents are excluded from this limitation. No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available without restriction for persons with mental illnesses include atypical antipsychotic medications, conventional antipsychotic medications, selective serotonin reuptake inhibitors, and other medications used for the treatment of serious mental illnesses. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply. The agency shall continue to provide unlimited generic drugs, contraceptive drugs and items, and diabetic supplies. Although a drug may be included on the preferred drug formulary, it would not be exempt from the four-brand limit. The agency may authorize exceptions to the brand-name-drug restriction based upon the treatment needs of the patients, only when such exceptions are based on prior consultation provided by the agency or an agency contractor, but the agency must establish procedures to ensure that:

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

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

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

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease-management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers.

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

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

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 25 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Effective July 1, 2003, value-added programs as a substitution for supplemental rebates are prohibited.~~Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug~~

~~utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act.~~The agency is authorized to seek any federal waivers to implement this initiative.

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

9. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid

prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

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

(39) Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times for such periods as the agency may decide; however, all such renewals may not combine to exceed a total period longer than the term of the original contract.

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

Section 7. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 ~~45~~ percent in MediPass and 60 ~~55~~ percent in managed care plans is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 40 ~~45~~ percent and 60 ~~55~~ percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(3)(g), Children's Medical Services network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health

maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. Beginning July 1, 2002, the agency shall assign all children in families who have not made a choice of a managed care plan or MediPass in the required timeframe to a pediatric emergency room diversion program described in s. 409.912(3)(g) that, as of July 1, 2002, has executed a contract with the agency, until such network or program has reached an enrollment of 15,000 children. Once that minimum enrollment level has been reached, the agency shall assign children who have not chosen a managed care plan or MediPass to the network or program in a manner that maintains the minimum enrollment in the network or program at not less than 15,000 children. To the extent practicable, the agency shall also assign all eligible children in the same family to such network or program. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 ~~45~~ percent in MediPass and 60 ~~55~~ percent in managed care plans is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 40 ~~45~~ percent and 60 ~~55~~ percent proportion, respectively. In geographic areas where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

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

Section 8. Subsection (2) of section 409.915, Florida Statutes, is amended to read:

409.915 County contributions to Medicaid.--Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

(2) A county's participation must be 35 percent of the total cost, or the applicable discounted cost paid by the state for Medicaid recipients enrolled in health maintenance organizations or prepaid health plans, of providing the items listed in subsection (1), except that the payments for items listed in paragraph (1)(b) may not exceed$70~~$55~~ per month per person.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

Section 9. Paragraph (q) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.--

(2) BENCHMARK BENEFITS.--In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(q) Dental services.--~~Subject to a specific appropriation for this benefit,~~Covered services include those dental services provided to children by the Florida Medicaid program under s. 409.906(5), up to a maximum benefit of $750 per enrollee per year.

Section 10. (1) Notwithstanding section 409.911(3), Florida Statutes, for the state fiscal year 2003-2004 only, the agency shall distribute moneys under the regular disproportionate share program only to hospitals that meet the federal minimum requirements and to public hospitals. Public hospitals are defined as those hospitals identified as government owned or operated in the Financial Hospital Uniform Reporting System (FHURS) data available to the agency as of January 1, 2002. The following methodology shall be used to distribute disproportionate share dollars to hospitals that meet the federal minimum requirements and to the public hospitals:

(a) For hospitals that meet the federal minimum requirements and do not qualify as a public hospital, the following formula shall be used:

DSHP = (HMD/TMSD)*$1 million

DSHP = disproportionate share hospital payment.
HMD = hospital Medicaid days.
TSD = total state Medicaid days.

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

1. For state mental health hospitals:

DSHP = (HMD/TMDMH) * TAAMH

The total amount available for the state mental health hospitals shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program.

2. For non-state government owned or operated hospitals with 3,200 or more Medicaid days:

DSHP = [(.82*HCCD/TCCD) + (.18*HMD/TMD)] * TAAPH
TAAPH = TAA - TAAMH

3. For non-state government owned or operated hospitals with less than 3,200 Medicaid days, a total of $400,000 shall be distributed equally among these hospitals.

Where:

TAA = total available appropriation.
TAAPH = total amount available for public hospitals.
TAAMH = total amount available for mental health hospitals.
DSHP = disproportionate share hospital payments.

HMD = hospital Medicaid days.
TMDMH = total state Medicaid days for mental health days.
TMD = total state Medicaid days for public hospitals.
HCCD = hospital charity care dollars.
TCCD = total state charity care dollars for public non-state hospitals.

In computing the above amounts for public hospitals and hospitals that qualify under the federal minimum requirements, the agency shall use the 1997 audited data. In the event there is no complete 1997 audited data for a hospital, the agency shall use the 1994 audited data.

(2) Notwithstanding section 409.9112, Florida Statutes, for state fiscal year 2003-2004, only disproportionate share payments to regional perinatal intensive care centers shall be distributed in the same proportion as the disproportionate share payments made to the regional perinatal intensive care centers in the state fiscal year 2001-2002.

(3) Notwithstanding section 409.9117, Florida Statutes, for state fiscal year 2003-2004 only, disproportionate share payments to hospitals that qualify for primary care disproportionate share payments shall be distributed in the same proportion as the primary care disproportionate share payments made to those hospitals in the state fiscal year 2001-2002.

(4) For state fiscal year 2003-2004 only, no disproportionate share payments for specialty hospitals for children shall be made to hospitals under the provisions of section 409.9119, Florida Statutes.

(5) This section is repealed on July 1, 2004.

Section 11. The Legislature finds and declares that this act fulfills an important state interest.

Section 12. Sections 1, 2, 3, 4, 8, and 11 of this act, and the part of section 6 of this act which amends the introductory portion of section 409.912, Florida Statutes, shall not take effect if one or more bills enacted during the 2003 legislative session, or an extension thereof, become law which increase receipts to the General Revenue Fund in an amount sufficient to support contingent appropriations in the 2003-2004 General Appropriations Act to:

(1) Increase certified nursing assistant staffing to 2.9 hours of direct care per resident per day, effective January 1, 2004;

(2) Provide Medicaid coverage for adults under the Medically Needy Program;

(3) Provide Medicaid coverage for adult emergency dental, visual, and hearing services;

(4) Not implement step-therapy protocols for Cox II drugs; and

(5) Continue county contributions for Medicaid nursing home care at the current level rather than an increased level.

Section 13. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2003.