An act relating to health care; amending s. 400.179, F.S.; deleting a repeal of provisions requiring payment of certain fees upon the transfer of the leasehold license for a nursing facility; 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 ss. 400.452 and 400.6211, F.S.; revising training requirements for administrators and staff of assisted living facilities and adult family-care home providers; requiring a competency test; providing rulemaking authority; amending s. 408.909, F.S., relating to health flex plans; revising eligibility for the plan; extending the expiration date of the program; amending s. 409.815, F.S., relating to benefits coverage under the Medicaid program; specifying a maximum annual benefit for children's dental services; amending s. 409.901, F.S.; defining the term "third party" to include a third-party administrator or pharmacy benefits manager; amending s. 409.904, F.S.; revising provisions governing the payment of optional medical benefits for certain Medicaid-eligible persons; amending s. 409.906, F.S.; revising requirements for hearing and visual services to limit such services to persons younger than 21 years of age; amending s. 409.9065, F.S.; revising the pharmaceutical

expense assistance program for low-income elderly individuals; adding eligibility groups; providing benefits; requiring the Agency for Health Care Administration, in administering the program, to collaborate with both the Department of Elderly Affairs and the Department of Children and Family Services; requiring federal approval of benefits; amending s. 409.908, F.S., relating to reimbursement of Medicaid providers; providing for a fee to be paid to providers returning unused medications and credited to the Medicaid program; amending s. 409.9081, F.S.; providing a copayment under the Medicaid program for certain nonemergency hospital visits; providing coinsurance of a specified amount for the Medicaid cost of prescription drugs; amending ss. 409.911, 409.9112, 409.9116, and 409.9117, F.S.; revising the disproportionate share program; deleting definitions; requiring the Agency for Health Care Administration to use actual audited data to determine the Medicaid days and charity care to be used to calculate the disproportionate share payment; revising formulas for calculating payments; revising the formula for calculating payments under the disproportionate share program for regional perinatal intensive care centers; providing for estimates of the payments under the rural disproportionate share and financial assistance programs; providing a formula for calculating

payments under the primary care disproportionate share program; amending s. 409.9119, F.S., relating to disproportionate share program for specialty hospitals for children; providing that payments are subject to appropriations; amending s. 409.912, F.S.; providing for reimbursement of provider service networks; authorizing the agency to implement a utilization management program for certain services and contract for certain dental services; amending s. 409.9122, F.S.; revising the percentage of Medicaid recipients required to be enrolled in managed care; revising requirements for the enrollment process; creating s. 430.83, F.S.; providing a popular name; providing definitions; providing legislative findings and intent; creating the Sunshine for Seniors Program to assist low-income seniors with obtaining prescription drugs from manufacturers' pharmaceutical assistance programs; providing implementation and oversight duties of the Department of Elderly Affairs; providing for community partnerships; providing for contracts; requiring annual evaluation reports on the program; specifying that the program is not an entitlement; amending s. 624.91, F.S., relating to the Florida Healthy Kids Corporation Act; providing for funding to be subject to specific appropriations; providing contract requirements; revising membership of the board

of directors of the corporation; repealing s. 57 of chapter 98-288, Laws of Florida; abrogating a repeal of the Florida Kidcare Act; authorizing the Agency for Health Care Administration to make additional payments to certain hospitals; specifying the amounts and providing for adjustments; providing for construction of the act in pari materia with laws enacted during the Regular Session of the Legislature; providing an effective date.

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

Section 1. Effective upon this act becoming a law, paragraph (d) of subsection (5) of section 400.179, Florida Statutes, is amended to read:

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

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

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

1. The transferee shall, as a condition to being issued a license by the agency, acquire, maintain, and provide proof to the agency of a bond with a term of 30 months, renewable annually, in an amount not less than the total of 3

months Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid at the time of any subsequent annual license renewal, in the amount of 2 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not available, projected Medicaid payments may be used. The fee shall be deposited into the Health Care Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and management of this account, including withdrawals from the account, subject to federal review and approval. ~~This subparagraph is repealed on June 30, 2003.~~This provision shall take effect upon becoming law and shall apply to any leasehold license application.

a. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency

through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits.

b. The agency, in consultation with the Florida Health Care Association and the Florida Association of Homes for the Aging, shall study and make recommendations on the minimum amount to be held in reserve to protect against Medicaid overpayments to leasehold licensees and on the issue of successor liability for Medicaid overpayments upon sale or transfer of ownership of a nursing facility. The agency shall submit the findings and recommendations of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

3. The leasehold licensee may meet the bond requirement through other arrangements acceptable to the agency. The agency is herein granted specific authority to promulgate rules pertaining to lease bond arrangements.

4. All existing nursing facility licensees, operating the facility as a leasehold, shall acquire, maintain, and provide proof to the agency of the 30-month bond required in subparagraph 1., above, on and after July 1, 1993, for each license renewal.

5. It shall be the responsibility of all nursing facility operators, operating the facility as a leasehold, to renew the 30-month bond and to provide proof of such renewal to the agency annually at the time of application for license renewal.

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, cancel,

revoke, or suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

Section 2. Paragraph (a) of subsection (3) of section 400.23, Florida Statutes, as amended by chapter 2003-1, Laws of Florida, 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 May ~~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 3. Section 400.452, Florida Statutes, is amended to read:

400.452 Staff training and educational programs; core educational requirement.--

(1) ~~The department shall provide, or cause to be provided, training and educational programs for the~~ Administrators and other assisted living facility staff must

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meet minimum training and education requirements established by the Department of Elderly Affairs by rule. This training and education is intended to assist facilities ~~to better enable them~~ to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

(2) The department shall ~~also~~ establish a competency test and a minimum required score to indicate successful completion of the training and ~~core~~ educational requirements ~~requirement to be used in these programs~~. The competency test must be developed by the department in conjunction with the agency and providers.~~Successful completion of the core educational requirement must include successful completion of a competency test. Programs must be provided by the department or by a provider approved by the department at least quarterly.~~ The required training and education ~~core educational requirement~~ must cover at least the following topics:

(a) State law and rules relating to assisted living facilities.

(b) Resident rights and identifying and reporting abuse, neglect, and exploitation.

(c) Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.

(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.

(g) Care of persons with Alzheimer's disease and related disorders.

(3) Effective January 1, 2004, ~~Such a program must be available at least quarterly in each planning and service area of the department. The competency test must be developed by the department in conjunction with the agency and providers.~~ a new facility administrator must complete the required training and education, ~~core educational requirement~~ including the competency test, within a reasonable time ~~3 months~~ after being employed as an administrator, as determined by the department. Failure to do so ~~complete a core educational requirement specified in this subsection~~ is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 400.419. Administrators licensed in accordance with chapter 468, part II, are exempt from this requirement. Other licensed professionals may be exempted, as determined by the department by rule.

(4) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

(5) Staff involved with the management of medications and assisting with the self-administration of medications under s. 400.4256 must complete a minimum of 4 additional hours of training ~~pursuant to a curriculum developed by the department and~~ provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training.

(6) Other facility staff shall participate in training relevant to their job duties as specified by rule of the department.

~~(7) A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee for such training and education programs. A facility that has one or more such residents shall pay a reduced fee that is proportional to the percentage of such residents in the facility. Any facility more than 90 percent of whose residents receive monthly optional state supplementation payments is not required to pay for the training and continuing education programs required under this section.~~

(7)~~(8)~~ If the department or the agency determines that there are problems in a facility that could be reduced through specific staff training or education beyond that already required under this section, the department or the agency may require, and provide, or cause to be provided, the training or education of any personal care staff in the facility.

(8)~~(9)~~ The department shall adopt rules related to these ~~establish training programs, standards and curriculum for training, staff~~ training requirements, the competency test, necessary procedures ~~for approving training programs~~, and competency test ~~training~~ fees.

Section 4. Section 400.6211, Florida Statutes, is amended to read:

400.6211 Training and education programs.--

(1) Each adult family-care home provider shall complete ~~The department must provide~~ training and education programs ~~for all adult family-care home providers~~.

(2) Training and education programs must include information relating to:

(a) State law and rules governing adult family-care homes, with emphasis on appropriateness of placement of residents in an adult family-care home.

(b) Identifying and reporting abuse, neglect, and exploitation.

(c) Identifying and meeting the special needs of disabled adults and frail elders.

(d) Monitoring the health of residents, including guidelines for prevention and care of pressure ulcers.

(3) Effective January 1, 2004, providers must complete the training and education program within a reasonable time determined by the department. Failure to complete the training and education program within the time set by the department is a violation of this part and subjects the provider to revocation of the license.

(4) If the Department of Children and Family Services, the agency, or the department determines that there are problems in an adult family-care home which could be reduced through specific training or education beyond that required under this section, the agency may require the provider or staff to complete such training or education.

(5) The department may adopt rules ~~shall specify by rule training and education programs, training requirements and the assignment of training responsibilities for staff, training procedures, and training fees~~ as necessary to administer this section.

Section 5. Paragraph (e) of subsection (2) and subsection (10) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.--

(2) DEFINITIONS.--As used in this section, the term:

(e) "Health flex plan" means a health plan approved under subsection (3) which guarantees payment for specified health care coverage provided to the enrollee who purchases coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government.

(10) EXPIRATION.--This section expires July 1, 2008 ~~2004~~.

Section 6. Paragraph (q) of subsection (2) of section 409.815, Florida Statutes, as amended by chapter 2003-1, Laws of Florida, 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 7. Subsection (25) of section 409.901, Florida Statutes, is amended to read:

409.901 Definitions; ss. 409.901-409.920.--As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(25) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should

be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid. A third party includes a third-party administrator or a pharmacy benefits manager.

Section 8. Subsection (2) of section 409.904, Florida Statutes, as amended by section 1 of chapter 2003-9, Laws of Florida, 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 family ~~caretaker relative or parent~~, a pregnant woman, a child under age 21 ~~19 who would otherwise qualify for Florida Kidcare Medicaid, 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 under any group listed in s. 409.903(1), (2), or (3) ~~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 July 1, 2003, when determining the eligibility of a pregnant woman, 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 9. Subsections (12) and (23) of section 409.906, Florida Statutes, are amended to read:

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

known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(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.

(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.

Section 10. Section 409.9065, Florida Statutes, is amended to read:

409.9065 Pharmaceutical expense assistance.--

(1) PROGRAM ESTABLISHED.--There is established a program to provide pharmaceutical expense assistance to eligible ~~certain~~ low-income elderly individuals, which shall be known as the "Ron Silver Senior Drug Program" and may be referred to as the "Lifesaver Rx Program."

(2) ELIGIBILITY.--Eligibility for the program is limited to ~~those~~ individuals who ~~qualify for limited assistance under the Florida Medicaid program as a result of being dually eligible for both Medicare and Medicaid, but whose limited assistance or Medicare coverage does not include any pharmacy benefit. To the extent funds are appropriated, specifically eligible individuals are individuals who~~:

(a) Are Florida residents age 65 and over;

(b) Have an income equal to or less than 200 percent of the federal poverty level;~~:~~

~~1. Between 88 and 120 percent of the federal poverty level;~~

~~2. Between 88 and 150 percent of the federal poverty level if the Federal Government increases the federal Medicaid match for persons between 100 and 150 percent of the federal poverty level; or~~

~~3. Between 88 percent of the federal poverty level and a level that can be supported with funds provided in the General Appropriations Act for the program offered under this section along with federal matching funds approved by the Federal Government under a s. 1115 waiver. The agency is authorized to submit and implement a federal waiver pursuant to this subparagraph. The agency shall design a pharmacy benefit that includes annual per-member benefit limits and cost-sharing provisions and limits enrollment to available appropriations and matching federal funds. Prior to implementing this program, the agency must submit a budget amendment pursuant to chapter 216;~~

(c) Are eligible for ~~both~~ Medicare ~~and Medicaid~~;

(d) Have exhausted pharmacy benefits under Medicare, Medicaid, or any other insurance plan ~~Are not enrolled in a Medicare health maintenance organization that provides a pharmacy benefit~~; and

(e) Request to be enrolled in the program.

(3) BENEFITS.--Eligible individuals shall receive a discount for prescription drugs ~~Medications~~ covered under ~~the pharmaceutical expense assistance program are those covered under~~ the Medicaid program in s. 409.906(20)~~(19)~~. ~~Monthly benefit payments shall be limited to $80 per program participant. Participants are required to make a 10-percent~~

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~~coinsurance payment for each prescription purchased through this program.~~

(a) Eligible individuals with incomes equal to or less than 120 percent of the federal poverty level shall receive a discount of 100 percent for the first $160 worth of prescription drugs they receive each month, subject to copayments that the agency requires on these benefits. For all other prescription drugs received each month, eligible individuals shall receive a discount of 50 percent.

(b) Eligible individuals with incomes of more than 120 percent but not more than 150 percent of the federal poverty level shall receive a discount of 50 percent.

(c) Eligible individuals with incomes of more than 150 percent but not more than 175 percent of the federal poverty level shall receive a discount of 41 percent.

(d) Eligible individuals with incomes of more than 175 percent but not more than 200 percent of the federal poverty level shall receive a discount of 37 percent.

(4) ADMINISTRATION.--The pharmaceutical expense assistance program shall be administered by the agency ~~for Health Care Administration~~, in collaboration ~~consultation~~ with the Department of Elderly Affairs and the Department of Children and Family Services.

~~(a) The Agency for Health Care Administration and the Department of Elderly Affairs shall develop a single-page application for the pharmaceutical expense assistance program.~~

(a)~~(b)~~ The agency ~~for Health Care Administration~~ shall, by rule, establish for the pharmaceutical expense assistance program eligibility requirements~~,~~ limits on participation~~,~~ benefit limitations, including copayments; a requirement for generic drug substitution~~,~~ and other program

parameters comparable to those of the Medicaid program. Individuals eligible to participate in this program are not subject to the limit of four brand name drugs per month per recipient as specified in s. 409.912(38)(a). There shall be no monetary limit on prescription drugs purchased with discounts of less than 51 percent unless the agency determines there is a risk of a funding shortfall in the program. If the agency determines there is a risk of a funding shortfall, the agency may establish monetary limits on prescription drugs which shall not be less than $160 worth of prescription drugs per month.

(b)~~(c)~~ By January 1 of each year, the agency ~~for Health Care Administration~~ shall report to the Legislature on the operation of the program. The report shall include information on the number of individuals served, use rates, and expenditures under the program. The report shall also address the impact of the program on reducing unmet pharmaceutical drug needs among the elderly and recommend programmatic changes.

(5) NONENTITLEMENT.--The pharmaceutical expense assistance program established by this section is not an entitlement. Enrollment levels are limited to those authorized by the Legislature in the annual General Appropriations Act. If, after establishing monetary limits as required by paragraph (4)(a), funds are insufficient to serve all eligible individuals ~~eligible under subsection (2) and~~ seeking coverage, the agency may develop a waiting list based on application dates to use in enrolling individuals in unfilled enrollment slots.

(6) PHARMACEUTICAL MANUFACTURER PARTICIPATION.--In order for a drug product to be covered under Medicaid or this program, the product's manufacturer shall:

(a) Provide a rebate to the state equal to the rebate required by the Medicaid program; and

(b) Make the drug product available to the program for the best price that the manufacturer makes the drug product available in the Medicaid program.

(7) REIMBURSEMENT.--Total reimbursements to pharmacies participating in the pharmaceutical expense assistance program established under this section shall be equivalent to reimbursements under the Medicaid program.

(8) FEDERAL APPROVAL.--The benefits provided in this section are limited to those approved by the Federal Government pursuant to a Medicaid waiver or an amendment to the state Medicaid plan.

Section 11. Subsection (14) 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.

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The agency is directed to implement a variable dispensing fee for payments for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred-drug-list products. The agency may ~~shall~~ increase the pharmacy dispensing fee authorized by statute and in the annual General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing

fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred-drug list. The agency may establish a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications to stock and crediting the Medicaid program for the ingredient cost of those medications if the ingredient costs to be credited exceed the value of the supplemental dispensing fee.The agency is authorized to limit reimbursement for prescribed medicine in order to comply with any limitations or directions provided for in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

Section 12. 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.

(d) Prescription drugs: a coinsurance equal to 2.5 percent of the Medicaid cost of the prescription drug at the time of purchase. The maximum coinsurance shall be $7.50 per prescription drug purchased.

Section 13. Section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) Definitions.--As used in this section, s. 409.9112, and the Florida Hospital Uniform Reporting System manual:

(a) "Adjusted patient days" means the sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(b) "Actual audited data" or "actual audited experience" means data reported to the Agency for Health Care Administration which has been audited in accordance with generally accepted auditing standards by the agency or representatives under contract with the agency.

~~(c) "Base Medicaid per diem" means the hospital's Medicaid per diem rate initially established by the Agency for Health Care Administration on January 1, 1999. The base Medicaid per diem rate shall not include any additional per diem increases received as a result of the disproportionate share distribution.~~

(c)~~(d)~~ "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.

(d)~~(e)~~ "Charity care days" means the sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

~~(f) "Disproportionate share percentage" means a rate of increase in the Medicaid per diem rate as calculated under this section.~~

(e)~~(g)~~ "Hospital" means a health care institution licensed as a hospital pursuant to chapter 395, but does not include ambulatory surgical centers.

(f)~~(h)~~ "Medicaid days" means the number of actual days attributable to Medicaid patients as determined by the Agency for Health Care Administration.

(2) The Agency for Health Care Administration shall use ~~utilize~~ the following actual audited data ~~criteria~~ to determine the Medicaid days and charity care to be used in

calculating the ~~if a hospital qualifies for a~~ disproportionate share payment:

(a) The average of the 1997, 1998, and 1999 audited data to determine each hospital's Medicaid days and charity care.

(b) The average of the audited disproportionate share data for the years available if the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share data for a hospital.

~~(a) A hospital's total Medicaid days when combined with its total charity care days must equal or exceed 7 percent of its total adjusted patient days.~~

~~(b) A hospital's total charity care days weighted by a factor of 4.5, plus its total Medicaid days weighted by a factor of 1, shall be equal to or greater than 10 percent of its total adjusted patient days.~~

(c) ~~Additionally,~~ In accordance with s. 1923(b) of the Social Security Act ~~the seventh federal Omnibus Budget Reconciliation 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) In computing the disproportionate share rate:~~

~~(a) Per diem increases earned from disproportionate share shall be applied to each hospital's base Medicaid per diem rate and shall be capped at 170 percent.~~

~~(b) The agency shall use 1994 audited financial data for the calculation of disproportionate share payments under this section.~~

~~(c) If the total amount earned by all hospitals under this section exceeds the amount appropriated, each hospital's~~

~~share shall be reduced on a pro rata basis so that the total dollars distributed from the trust fund do not exceed the total amount appropriated.~~

~~(d) The total amount calculated to be distributed under this section shall be made in quarterly payments subsequent to each quarter during the fiscal year.~~

(3)~~(4)~~ 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)*$1 million

Where:

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

~~TAA = TA x (1/5.5)~~
~~DSHP = (HMD/TSMD) x TAA~~

~~Where:~~

~~TAA = total amount available.~~
~~TA = total appropriation.~~
~~DSHP = disproportionate share hospital payment.~~
~~HMD = hospital Medicaid days.~~
~~TSMD = total state Medicaid days.~~

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

(a) For state mental health hospitals:

DSHP = (HMD/TMDMH) * TAAMH

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

Where:

DSHP = disproportionate share hospital payment.
HMD = hospital Medicaid days.
TMDHH = total Medicaid days for state mental health hospitals.
TAAMH = total amount available for mental health hospitals.

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

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

Where:

TAA = total available appropriation.
TAAPH = total amount available for public hospitals.
DSHP = disproportionate share hospital payments.
HMD = hospital Medicaid days.
TMD = total state Medicaid days for public hospitals.
HCCD = hospital charity care dollars.

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

(c) For non-state government owned or operated hospitals with less than 3,300 Medicaid days, a total of $400,000 shall be distributed equally among these hospitals.

~~(5) The following formula shall be utilized by the agency to determine the maximum disproportionate share rate to be used to increase the Medicaid per diem rate for hospitals that qualify pursuant to paragraphs (2)(a) and (b):~~

$$DSR = \left(\frac{CCD}{APD} \times 4.5\right) + \frac{MD}{APD}$$

~~Where:~~

~~APD = adjusted patient days.~~

~~CCD = charity care days.~~

~~DSR = disproportionate share rate.~~

~~MD = Medicaid days.~~

~~(6)(a) To calculate the total amount earned by all hospitals under this section, hospitals with a disproportionate share rate less than 50 percent shall divide their Medicaid days by four, and hospitals with a disproportionate share rate greater than or equal to 50 percent and with greater than 40,000 Medicaid days shall multiply their Medicaid days by 1.5, and the following formula shall be used by the agency to calculate the total amount earned by all hospitals under this section:~~

$$TAE = BMPD \times MD \times DSP$$

~~Where:~~

~~TAE = total amount earned.~~

~~BMPD = base Medicaid per diem.~~

~~MD = Medicaid days.~~

~~DSP = disproportionate share percentage.~~

(5)~~(b)~~ In no case shall total payments to a hospital under this section, with the exception of public non-state facilities or state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the agency according to the most recent calendar year audited data available at the beginning of each state fiscal year.

~~(7) The following criteria shall be used in determining the disproportionate share percentage:~~

~~(a) If the disproportionate share rate is less than 10 percent, the disproportionate share percentage is zero and there is no additional payment.~~

~~(b) If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, then the disproportionate share percentage is 1.8478498.~~

~~(c) If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, then the disproportionate share percentage is 3.4145488.~~

~~(d) If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, then the disproportionate share percentage is 6.3095734.~~

~~(e) If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, then the disproportionate share percentage is 11.6591440.~~

~~(f) If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, then the disproportionate share percentage is 73.5642254.~~

~~(g) If the disproportionate share rate is greater than or equal to 60 percent but less than 72.5 percent, then the disproportionate share percentage is 135.9356391.~~

~~(h) If the disproportionate share rate is greater than or equal to 72.5 percent, then the disproportionate share percentage is 170.~~

~~(8) The following formula shall be used by the agency to calculate the total amount earned by all hospitals under this section:~~

~~TAE = BMPD x MD x DSP~~

~~Where:~~

~~TAE = total amount earned.~~

~~BMPD = base Medicaid per diem.~~

~~MD = Medicaid days.~~

~~DSP = disproportionate share percentage.~~

(6)~~(9)~~ The agency is authorized to receive funds from local governments and other local political subdivisions for the purpose of making payments, including federal matching funds, through the Medicaid disproportionate share program. Funds received from local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(7)~~(10)~~ Payments made by the agency to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.

(a) If the Federal Government prohibits, restricts, or changes in any manner the methods by which funds are distributed for this program, the agency shall not distribute any additional funds and shall return all funds to the local government from which the funds were received, except as provided in paragraph (b).

(b) If the Federal Government imposes a restriction that still permits a partial or different distribution, the agency may continue to disburse funds to hospitals participating in the disproportionate share program in a federally approved manner, provided:

1. Each local government which contributes to the disproportionate share program agrees to the new manner of distribution as shown by a written document signed by the governing authority of each local government; and

2. The Executive Office of the Governor, the Office of Planning and Budgeting, the House of Representatives, and the Senate are provided at least 7 days' prior notice of the proposed change in the distribution, and do not disapprove such change.

(c) No distribution shall be made under the alternative method specified in paragraph (b) unless all parties agree or unless all funds of those parties that disagree which are not yet disbursed have been returned to those parties.

(8)~~(11)~~ Notwithstanding the provisions of chapter 216, the Executive Office of the Governor is hereby authorized to establish sufficient trust fund authority to implement the disproportionate share program.

Section 14. Section 409.9112, Florida Statutes, is amended to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the regional perinatal intensive care center program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a regional perinatal intensive care center.

HDSP = the prior state fiscal year regional perinatal intensive care center disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total regional perinatal intensive care center disproportionate share payments to all hospitals.

(2) The total additional payment for hospitals that participate in the regional perinatal intensive care center program shall be calculated by the agency as follows:

TAP = TAE * TA

Where:

TAP = total additional payment for a regional perinatal intensive care center.

TAE = total amount earned by a regional perinatal intensive care center.

TA = total appropriation for the regional perinatal intensive care center disproportionate share program.

~~TAE = DSR x BMPD x MD~~

~~Where:~~

~~TAE = total amount earned by a regional perinatal intensive care center.~~

~~DSR = disproportionate share rate.~~

~~BMPD = base Medicaid per diem.~~

~~MD = Medicaid days.~~

~~(2) The total additional payment for hospitals that participate in the regional perinatal intensive care center program shall be calculated by the agency as follows:~~

~~TAE x TA~~

~~$$TAP = (\ldots\ldots\ldots\ldots)$$~~
~~$$STAE$$~~

~~Where:~~

~~TAP = total additional payment for a regional perinatal intensive care center.~~

~~TAE = total amount earned by a regional perinatal intensive care center.~~

~~STAE = sum of total amount earned by each hospital that participates in the regional perinatal intensive care center program.~~

~~TA = total appropriation for the regional perinatal intensive care disproportionate share program.~~

(3) In order to receive payments under this section, a hospital must be participating in the regional perinatal intensive care center program pursuant to chapter 383 and must meet the following additional requirements:

(a) Agree to conform to all departmental and agency requirements to ensure high quality in the provision of services, including criteria adopted by departmental and agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department and agency deem appropriate as specified by rule.

(b) Agree to provide information to the department and agency, in a form and manner to be prescribed by rule of the department and agency, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

(c) Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

(d) Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

(e) Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

(f) Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

(g) Agree to provide backup and referral services to the department's county health departments and other low-income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

(h) Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

(4) Hospitals which fail to comply with any of the conditions in subsection (3) or the applicable rules of the department and agency shall not receive any payments under this section until full compliance is achieved. A hospital which is not in compliance in two or more consecutive quarters shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating regional perinatal intensive care center program hospitals.

Section 15. Subsection (1) of section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share/financial assistance program for rural hospitals.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall administer a federally matched disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. The disproportionate share program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program or the financial assistance program:

TAERH = (CCD + MDD)/TPD

Where:

CCD = total charity care-other, plus charity care-Hill-Burton, minus 50 percent of unrestricted tax revenue from local governments, and restricted funds for indigent care, divided by gross revenue per adjusted patient day;

however, if CCD is less than zero, then zero shall be used for CCD.

MDD = Medicaid inpatient days plus Medicaid HMO inpatient days.

TPD = total inpatient days.

TAERH = total amount earned by each rural hospital.

In computing the total amount earned by each rural hospital, the agency must use the average of the 3 most recent years of actual data reported in accordance with s. 408.061(4)(a). The agency shall provide a preliminary estimate of the payments under the rural disproportionate share and financial assistance programs to the rural hospitals by August 31 of each state fiscal year for review. Each rural hospital shall have 30 days to review the preliminary estimates of payments and report any errors to the agency. The agency shall make any corrections deemed necessary and compute the rural disproportionate share and financial assistance program payments.

Section 16. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE * TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

(b) Ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

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

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

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

promote and protect the public health within the agreed geopolitical boundaries.

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

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

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

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

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

Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may

not receive payments under this section until full compliance is achieved.

Section 17. Section 409.9119, Florida Statutes, is amended to read:

409.9119 Disproportionate share program for specialty hospitals for children.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall develop and implement a system under which disproportionate share payments are made to those hospitals that are licensed by the state as specialty hospitals for children and were licensed on January 1, 2000, as specialty hospitals for children. This system of payments must conform to federal requirements and must distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals that serve a disproportionate share of low-income patients. Payments are subject to specific appropriations in the General Appropriations Act.

(1) The agency shall use the following formula to calculate the total amount earned for hospitals that participate in the specialty hospital for children disproportionate share program:

TAE = DSR x BMPD x MD

Where:

TAE = total amount earned by a specialty hospital for children.

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

(2) The agency shall calculate the total additional payment for hospitals that participate in the specialty hospital for children disproportionate share program as follows:

$$TAP = \left(\frac{TAE \times TA}{STAE}\right)$$

Where:

TAP = total additional payment for a specialty hospital for children.

TAE = total amount earned by a specialty hospital for children.

TA = total appropriation for the specialty hospital for children disproportionate share program.

STAE = sum of total amount earned by each hospital that participates in the specialty hospital for children disproportionate share program.

(3) A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of the agency. A hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating specialty hospitals for children that are in compliance.

Section 18. Paragraph (d) of subsection (3) of section 409.912, Florida Statutes, as amended by chapter 2003-1, Laws

of Florida, is amended, and subsections (41) and (42) are added to that section, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. 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. 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.

(3) The agency may contract with:

(d) A provider service network ~~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.~~

(41) The agency shall develop and implement a utilization management program for Medicaid-eligible recipients for the management of occupational, physical, respiratory, and speech therapies. The agency shall establish a utilization program that may require prior authorization in order to ensure medically necessary and cost-effective treatments. The program shall be operated in accordance with a federally approved waiver program or state plan amendment. The agency may seek a federal waiver or state plan amendment to implement this program. The agency may also competitively procure these services from an outside vendor on a regional or statewide basis.

(42) The agency may contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services.

Section 19. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, are amended, and subsection (13) is added to that section, 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.

1. 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. This subparagraph expires January 1, 2004.

2. When making assignments, the agency shall take into account the following criteria:

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

b.~~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.

c.~~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.

d.~~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.

(13) Effective July 1, 2003, the agency shall adjust the enrollee assignment process of Medicaid managed prepaid health plans for those Medicaid managed prepaid plans operating in Miami-Dade County which have executed a contract with the agency for a minimum of 8 consecutive years in order for the Medicaid managed prepaid plan to maintain a minimum enrollment level of 15,000 members per month.

Section 20. Section 430.83, Florida Statutes, is created to read:

430.83 Sunshine for Seniors Program.--

(1) POPULAR NAME.--This section shall be known by the popular name "The Sunshine for Seniors Act."

(2) DEFINITIONS.--As used in this section, the term:

(a) "Application assistance organization" means any private organization that assists individuals with obtaining

prescription drugs through manufacturers' pharmaceutical assistance programs.

(b) "Eligible individual" means any individual who is 60 years of age or older who lacks adequate pharmaceutical insurance coverage.

(c) "Manufacturers' pharmaceutical assistance program" means any program offered by a pharmaceutical manufacturer which provides low-income individuals with prescription drugs free or at reduced prices, including, but not limited to, senior discount card programs and patient assistance programs.

(3) LEGISLATIVE FINDINGS AND INTENT.--The Legislature finds that the pharmaceutical manufacturers, seeing a need, have created charitable programs to aid low-income seniors with the cost of prescription drugs. The Legislature also finds that many low-income seniors are unaware of such programs or either do not know how to apply for or need assistance in completing the applications for such programs. Therefore, it is the intent of the Legislature that the Department of Elderly Affairs, in consultation with the Agency for Health Care Administration, implement and oversee the Sunshine for Seniors Program to help seniors in accessing manufacturers' pharmaceutical assistance programs.

(4) SUNSHINE FOR SENIORS PROGRAM.--There is established a program to assist low-income seniors with obtaining prescription drugs from manufacturers' pharmaceutical assistance programs, which shall be known as the "Sunshine for Seniors Program." Implementation of the program is subject to the availability of funding and any limitations or directions provided for by the General Appropriations Act or chapter 216.

(5) IMPLEMENTATION AND OVERSIGHT DUTIES.--In implementing and overseeing the Sunshine for Seniors Program, the Department of Elderly Affairs:

(a) Shall promote the availability of manufacturers' pharmaceutical assistance programs to eligible individuals with various outreach initiatives.

(b) Shall, working cooperatively with pharmaceutical manufacturers and consumer advocates, develop a uniform application form to be completed by seniors who wish to participate in the Sunshine for Seniors Program.

(c) May request proposals from application assistance organizations to assist eligible individuals with obtaining prescription drugs through manufacturers' pharmaceutical assistance programs.

(d) Shall train volunteers to help eligible individuals fill out applications for the manufacturers' pharmaceutical assistance programs.

(e) Shall train volunteers to determine when applicants may be eligible for other state programs and refer them to the proper entity for eligibility determination for such programs.

(f) Shall seek federal funds to help fund the Sunshine for Seniors Program.

(g) May seek federal waivers to help fund the Sunshine for Seniors Program.

(6) COMMUNITY PARTNERSHIPS.--The Department of Elderly Affairs may build private-sector and public-sector partnerships with corporations, hospitals, physicians, pharmacists, foundations, volunteers, state agencies, community groups, area agencies on aging, and any other entities that will further the intent of this section. These

community partnerships may also be used to facilitate other pro bono benefits for eligible individuals, including, but not limited to, medical, dental, and prescription services.

(7) CONTRACTS.--The Department of Elderly Affairs may select and contract with application assistance organizations to assist eligible individuals in obtaining their prescription drugs through the manufacturers' pharmaceutical assistance programs. If the department contracts with an application assistance organization, the department shall evaluate quarterly the performance of the application assistance organization to ensure compliance with the contract and the quality of service provided to eligible individuals.

(8) REPORTS AND EVALUATIONS.--By January 1 of each year, while the Sunshine for Seniors Program is operating, the Department of Elderly Affairs shall report to the Legislature regarding the implementation and operation of the Sunshine for Seniors Program.

(9) NONENTITLEMENT.--The Sunshine for Seniors Program established by this section is not an entitlement. If funds are insufficient to assist all eligible individuals, the Department of Elderly Affairs may develop a waiting list prioritized by application date.

Section 21. Paragraph (b) of subsection (2), paragraph (b) of subsection (4), and paragraph (a) of subsection (5) of section 624.91, Florida Statutes, are amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(2) LEGISLATIVE INTENT.--

(b) It is the intent of the Legislature that the Florida Healthy Kids Corporation serve as one of several providers of services to children eligible for medical assistance under Title XXI of the Social Security Act.

Although the corporation may serve other children, the Legislature intends the primary recipients of services provided through the corporation be school-age children with a family income below 200 percent of the federal poverty level, who do not qualify for Medicaid. It is also the intent of the Legislature that state and local government Florida Healthy Kids funds be used to continue and expand coverage, subject to specific ~~within available~~ appropriations in the General Appropriations Act, to children not eligible for federal matching funds under Title XXI.

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

(b) The Florida Healthy Kids Corporation shall:

~~1. Organize school children groups to facilitate the provision of comprehensive health insurance coverage to children;~~

1.~~2.~~ Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses;

2.~~3.~~ Arrange for the collection of any voluntary contributions to provide for payment of premiums for children who are not eligible for medical assistance under Title XXI of the Social Security Act. Each fiscal year, the corporation shall establish a local match policy for the enrollment of non-Title-XXI-eligible children in the Healthy Kids program. By May 1 of each year, the corporation shall provide written notification of the amount to be remitted to the corporation for the following fiscal year under that policy. Local match sources may include, but are not limited to, funds provided by municipalities, counties, school boards, hospitals, health

care providers, charitable organizations, special taxing districts, and private organizations. The minimum local match cash contributions required each fiscal year and local match credits shall be determined by the General Appropriations Act. The corporation shall calculate a county's local match rate based upon that county's percentage of the state's total non-Title-XXI expenditures as reported in the corporation's most recently audited financial statement. In awarding the local match credits, the corporation may consider factors including, but not limited to, population density, per capita income, and existing child-health-related expenditures and services;

3.~~4.~~ Accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional coverage in contributing counties under Title XXI;

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

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

6.~~7.~~ Establish eligibility criteria which children must meet in order to participate in the program;

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

8.~~9.~~ Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or insurance administrator to provide administrative services to the corporation;

9.~~10.~~ Establish enrollment criteria which shall include penalties or waiting periods of not fewer than 60 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums;

10.~~11.~~ If a space is available, establish a special open enrollment period of 30 days' duration for any child who is enrolled in Medicaid or Medikids if such child loses Medicaid or Medikids eligibility and becomes eligible for the Florida Healthy Kids program;

11.~~12.~~ Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. The minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent.The selection of health plans shall be based primarily on quality criteria established by the board. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded;

12.~~13.~~ Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments;

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

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

15.~~16.~~ As appropriate, enter into contracts with local school boards or other agencies to provide onsite information, enrollment, and other services necessary to the operation of the corporation;

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

17.~~18.~~ Each fiscal year, establish a maximum number of participants, on a statewide basis, who may enroll in the program; and

18.~~19.~~ Establish eligibility criteria, premium and cost-sharing requirements, and benefit packages which conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.820.

(5) BOARD OF DIRECTORS.--

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors chaired by the Chief Financial Officer or her or his

designee, and composed of 10 ~~14~~ other members selected for 3-year terms of office as follows:

1. The Secretary of Health Care Administration, or his or her designee;

~~1. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Administrators;~~

~~2. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Boards;~~

2.~~3.~~ One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education;

3.~~4.~~ One member appointed by the Chief Financial Officer ~~Governor~~ from among three members nominated by the Florida Pediatric Society;

4.~~5.~~ One member, appointed by the Governor, who represents the Children's Medical Services Program;

5.~~6.~~ One member appointed by the Chief Financial Officer from among three members nominated by the Florida Hospital Association;

~~7. Two members, appointed by the Chief Financial Officer, who are representatives of authorized health care insurers or health maintenance organizations;~~

6.~~8.~~ One member, appointed by the Governor ~~Chief Financial Officer~~, who is an expert on ~~represents the Institute for~~ child health policy;

7.~~9.~~ One member, appointed by the Chief Financial Officer ~~Governor~~, from among three members nominated by the Florida Academy of Family Physicians;

8.~~10.~~ One member, appointed by the Governor, who represents the state Medicaid program ~~Agency for Health Care Administration~~;

~~11. One member, appointed by the Chief Financial Officer, from among three members nominated by the Florida Association of Counties, representing rural counties;~~

9.~~12.~~ One member, appointed by the Chief Financial Officer ~~Governor~~, from among three members nominated by the Florida Association of Counties~~, representing urban counties~~; and

10.~~13.~~ The State Health Officer or her or his designee.

Section 22. Section 57 of chapter 98-288, Laws of Florida, is repealed.

Section 23. Effective upon this act becoming a law, for the 2002-2003 state fiscal year, the Agency for Health Care Administration may make additional payment of up to $7,561,104 from the Grants and Donations Trust Fund and $10,849,182 from the Medical Care Trust Fund to hospitals as special Medicaid payments in order to use the full amount of the upper payment limit available in the public hospital category.

(1) These funds shall be distributed as follows:

(a) Statutory teaching hospitals - $1,355,991.

(b) Family practice teaching hospitals - $181,291.

(c) Primary care hospitals - $1,355,991.

(d) Trauma hospitals - $1,290,000.

(e) Rural hospitals - $931,500.

(f) Hospitals receiving specific special Medicaid payments not included in a payment under paragraphs (a)-(e), $4,359,417.

(g) Hospitals providing enhanced services to low-income individuals - $8,884,298.

(2) The payments shall be distributed proportionately to each hospital in the specific payment category based on the hospital's actual payments for the 2002-2003 state fiscal year. These payment amounts shall be adjusted downward in a proportionate manner as to not exceed the available upper payment limit in the public hospital category. Payment of these amounts are contingent on the state share being provided through grants and donations from state, county, or other local funds and approval by the Centers of Medicare and Medicaid Services.

Section 24. If any law that is amended by this act was also amended by a law enacted at the 2003 Regular Session of the Legislature, such laws shall be construed as if they had been enacted during the same session of the Legislature, and full effect should be given to each if that is possible.

Section 25. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2003.