1 A bill to be entitled
2 An act relating to health care; amending s. 400.23, F.S.;
3 delaying a nursing home staffing increase; providing for
4 retroactive application; amending s. 408.909, F.S.;
5 providing additional eligibility; amending s. 409.8134,
6 F.S.; revising a date for eligibility to be exempt from
7 reapplying; amending s. 409.814, F.S.; providing
8 additional eligibility for KidCare; requiring proof of
9 family income with supporting documents; amending s.
10 409.903, F.S.; eliminating services for certain persons;
11 providing income deductions; amending s. 409.905, F.S.,
12 relating to mandatory Medicaid services; requiring
13 utilization management of private duty nursing services;
14 establishing a hospitalist program; limiting payment for
15 bed hold days for nursing facilities; amending s. 409.906,
16 F.S., relating to optional Medicaid services; providing
17 for adult denture and adult hearing and visual services;
18 eliminating vacancy interim rates for intermediate care
19 facility for the developmentally disabled services;
20 requiring utilization management for home and community-
21 based services; consolidating home and community-based
22 services; amending s. 409.9065, F.S.; authorizing the
23 agency to operate a pharmaceutical expense assistance
24 program under certain circumstances; amending s. 409.907,
25 F.S.; revising Medicaid provider agreement requirements;
26 amending s. 409.908, F.S.; revising guidelines relating to
27 reimbursement of Medicaid providers; mandating the payment
28 method of county health departments; amending s. 409.911,
29 F.S.; requiring the convening of the Medicaid

30 Disproportionate Share Council and providing duties
31 thereof; amending ss. 409.9112, 409.9113, and 409.9117,
32 F.S.; restricting the agency from distributing certain
33 funds; amending s. 409.912, F.S.; granting Medicaid
34 provider network management; providing limits on certain
35 drugs; providing for management of mental health drugs;
36 reducing payment for pharmaceutical ingredient prices;
37 expanding the existing pharmaceutical supplemental rebate
38 threshold; correcting cross references; amending s.
39 409.9124, F.S.; requiring the agency to publish managed
40 care rates annually; amending s. 624.91, F.S.; revising
41 Healthy Kids contract requirements; requiring certain
42 programs be provided in certain counties; requiring the
43 agency to negotiate to reduce costs; requiring a review by
44 the Office of Program Policy Analysis and Government
45 Accountability; requiring a report; authorizing the Agency
46 for Health Care Administration to contract on a capitated,
47 prepaid, or fixed-sum basis with a laboratory service
48 provider to provide statewide laboratory services for
49 Medicaid recipients; requiring the agency to ensure that
50 it secures laboratory values from Medicaid-enrolled
51 laboratories for all tests provided to Medicaid recipients
52 and to include such data in the Medicaid real-time web-
53 based reporting system that interfaces with a real time
54 web-based prescription ordering and tracking system;
55 providing effective dates.
56
57 Be It Enacted by the Legislature of the State of Florida:
58

59 Section 1. Effective upon this act becoming a law and
60 applying retroactively to May 1, 2004, paragraph (a) of
61 subsection (3) of section 400.23, Florida Statutes, is amended
62 to read:
63 400.23 Rules; evaluation and deficiencies; licensure
64 status.--
65 (3)(a) The agency shall adopt rules providing for the
66 minimum staffing requirements for nursing homes. These
67 requirements shall include, for each nursing home facility, a
68 minimum certified nursing assistant staffing of 2.3 hours of
69 direct care per resident per day beginning January 1, 2002,
70 increasing to 2.6 hours of direct care per resident per day
71 beginning January 1, 2003, and increasing to 2.9 hours of direct
72 care per resident per day beginning July ~~May~~ 1, 2005 ~~2004~~.
73 Beginning January 1, 2002, no facility shall staff below one
74 certified nursing assistant per 20 residents, and a minimum
75 licensed nursing staffing of 1.0 hour of direct resident care
76 per resident per day but never below one licensed nurse per 40
77 residents. Nursing assistants employed never below one licensed
78 nurse per 40 residents. Nursing assistants employed under s.
79 400.211(2) may be included in computing the staffing ratio for
80 certified nursing assistants only if they provide nursing
81 assistance services to residents on a full-time basis. Each
82 nursing home must document compliance with staffing standards as
83 required under this paragraph and post daily the names of staff
84 on duty for the benefit of facility residents and the public.
85 The agency shall recognize the use of licensed nurses for
86 compliance with minimum staffing requirements for certified
87 nursing assistants, provided that the facility otherwise meets

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88 the minimum staffing requirements for licensed nurses and that
89 the licensed nurses so recognized are performing the duties of a
90 certified nursing assistant. Unless otherwise approved by the
91 agency, licensed nurses counted towards the minimum staffing
92 requirements for certified nursing assistants must exclusively
93 perform the duties of a certified nursing assistant for the
94 entire shift and shall not also be counted towards the minimum
95 staffing requirements for licensed nurses. If the agency
96 approved a facility's request to use a licensed nurse to perform
97 both licensed nursing and certified nursing assistant duties,
98 the facility must allocate the amount of staff time specifically
99 spent on certified nursing assistant duties for the purpose of
100 documenting compliance with minimum staffing requirements for
101 certified and licensed nursing staff. In no event may the hours
102 of a licensed nurse with dual job responsibilities be counted
103 twice.

104 Section 2. Paragraphs (c) and (d) of subsection (5) of
105 section 408.909, Florida Statutes, are redesignated as
106 paragraphs (d) and (e), respectively, present paragraph (c) of
107 subsection (5) of said section is amended, and a new paragraph
108 (c) is added to said subsection, to read:

109 408.909 Health flex plans.--

110 (5) ELIGIBILITY.--Eligibility to enroll in an approved
111 health flex plan is limited to residents of this state who:

112 (c) Are eligible under a federally approved Medicaid
113 demonstration waiver and reside in Palm Beach County or Miami-
114 Dade County;

115 (d) ~~(c)~~ Are not covered by a private insurance policy and
116 are not eligible for coverage through a public health insurance

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117 program, such as Medicare or Medicaid, unless specifically
118 authorized under paragraph (c), or another public health care
119 program, such as KidCare, and have not been covered at any time
120 during the past 6 months; and
121 Section 3. Subsection (2) of section 409.8134, Florida
122 Statutes, as amended by chapter 2004-1, Laws of Florida, is
123 amended to read:
124 409.8134 Program enrollment and expenditure ceilings.--
125 (2) Upon a unanimous recommendation by representatives
126 from each of the four Florida KidCare administrators, the
127 Florida KidCare program may conduct an open enrollment period
128 for the purpose of enrolling children eligible for all program
129 components listed in s. 409.813 except Medicaid. The four
130 Florida KidCare administrators shall work together to ensure
131 that the open enrollment period is announced statewide at least
132 1 month before the open enrollment is to begin. Eligible
133 children shall be enrolled on a first-come, first-served basis
134 using the date the open enrollment application is received. The
135 potential open enrollment periods shall be January 1st through
136 January 30th and September 1st through September 30th. Open
137 enrollment shall immediately cease when the enrollment ceiling
138 is reached ~~reaches~~. An open enrollment shall only be held if the
139 Social Services Estimating Conference determines that sufficient
140 federal and state funds will be available to finance the
141 increased enrollment through federal fiscal year 2007. Any
142 individual who is not enrolled, including those added to the
143 waiting list after March 11 ~~January 30~~, 2004, must reapply by
144 submitting a new application during the next open enrollment
145 period. However, the Children's Medical Services Network may

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146 annually enroll up to 120 additional children based on emergency
147 disability criteria outside of the open enrollment periods and
148 the cost of serving these children must be managed within the
149 KidCare program's appropriated or authorized levels of funding.
150 Except for the Medicaid program, whenever the Social Services
151 Estimating Conference determines that there is presently, or
152 will be by the end of the current fiscal year, insufficient
153 funds to finance the current or projected enrollment in the
154 Florida KidCare program, all additional enrollment must cease
155 and additional enrollment may not resume until sufficient funds
156 are available to finance such enrollment.
157
158 Section 4. Paragraph (f) of subsection (4) and paragraph
159 (a) of subsection (8) of section 409.814, Florida Statutes, as
160 amended by chapter 2004-1, Laws of Florida, are amended, and
161 paragraph (g) is added to subsection (4) of said section, to
162 read:
163 409.814 Eligibility.--A child who has not reached 19 years
164 of age whose family income is equal to or below 200 percent of
165 the federal poverty level is eligible for the Florida KidCare
166 program as provided in this section. For enrollment in the
167 Children's Medical Services network, a complete application
168 includes the medical or behavioral health screening. If,
169 subsequently, an individual is determined to be ineligible for
170 coverage, he or she must immediately be disenrolled from the
171 respective Florida KidCare program component.
172 (4) The following children are not eligible to receive
173 premium assistance for health benefits coverage under the
174 Florida KidCare program, except under Medicaid if the child

175 would have been eligible for Medicaid under s. 409.903 or s.
176 409.904 as of June 1, 1997:
177 (f) A child who has had his or her coverage in an
178 employer-sponsored health benefit plan voluntarily canceled in
179 the last 6 months, except those children who were on the waiting
180 list prior to March 12 ~~January 31~~, 2004.
181 (g) A child who is otherwise eligible for KidCare and who
182 has a preexisting condition that prevents coverage under another
183 insurance plan as described in paragraph (b) which would have
184 disqualified the child for KidCare if the child were able to
185 enroll in the plan shall be eligible for KidCare coverage when
186 enrollment is possible.
187 (8) In determining the eligibility of a child, an assets
188 test is not required. Each applicant shall provide written
189 documentation during the application process and the
190 redetermination process, including, but not limited to, the
191 following:
192 (a) Proof of family income supported by copies of any
193 federal income tax return for the prior year, any wages and
194 earnings statements (W-2 forms), and any other appropriate
195 document.
196 Section 5. Effective January 1, 2005, subsection (6) of
197 section 409.814, Florida Statutes, as amended by chapter 2004-1,
198 Laws of Florida, is amended to read:
199 409.814 Eligibility.--A child who has not reached 19 years
200 of age whose family income is equal to or below 200 percent of
201 the federal poverty level is eligible for the Florida KidCare
202 program as provided in this section. For enrollment in the
203 Children's Medical Services network, a complete application

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204 includes the medical or behavioral health screening. If,
205 subsequently, an individual is determined to be ineligible for
206 coverage, he or she must immediately be disenrolled from the
207 respective Florida KidCare program component.
208 (6) Once a child is enrolled in the Florida KidCare
209 program, the child is eligible for coverage under the program
210 for 12 ~~6~~ months without a redetermination or reverification of
211 eligibility, if the family continues to pay the applicable
212 premium. Eligibility for program components funded through Title
213 XXI of the Social Security Act shall terminate when a child
214 attains the age of 19. Effective January 1, 1999, a child who
215 has not attained the age of 5 and who has been determined
216 eligible for the Medicaid program is eligible for coverage for
217 12 months without a redetermination or reverification of
218 eligibility.
219 Section 6. Subsection (5) of section 409.903, Florida
220 Statutes, is amended to read:
221 409.903 Mandatory payments for eligible persons.--The
222 agency shall make payments for medical assistance and related
223 services on behalf of the following persons who the department,
224 or the Social Security Administration by contract with the
225 Department of Children and Family Services, determines to be
226 eligible, subject to the income, assets, and categorical
227 eligibility tests set forth in federal and state law. Payment on
228 behalf of these Medicaid eligible persons is subject to the
229 availability of moneys and any limitations established by the
230 General Appropriations Act or chapter 216.
231 (5) A pregnant woman for the duration of her pregnancy and
232 for the postpartum period as defined in federal law and rule, or

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233 a child under age 1, if either is living in a family that has an
234 income which is at or below 150 percent of the most current
235 federal poverty level, or, effective January 1, 1992, that has
236 an income which is at or below 185 percent of the most current
237 federal poverty level. Such a person is not subject to an assets
238 test. Further, a pregnant woman who applies for eligibility for
239 the Medicaid program through a qualified Medicaid provider must
240 be offered the opportunity, subject to federal rules, to be made
241 presumptively eligible for the Medicaid program. Effective July
242 1, 2005, eligibility for Medicaid services is eliminated for
243 women who have incomes above 150 percent of the most current
244 federal poverty level.
245 Section 7. Subsections (2) and (3) of section 409.904,
246 Florida Statutes, are amended to read:
247 409.904 Optional payments for eligible persons.--The
248 agency may make payments for medical assistance and related
249 services on behalf of the following persons who are determined
250 to be eligible subject to the income, assets, and categorical
251 eligibility tests set forth in federal and state law. Payment on
252 behalf of these Medicaid eligible persons is subject to the
253 availability of moneys and any limitations established by the
254 General Appropriations Act or chapter 216.
255 (2) A family, a pregnant woman, a child under age 21, a
256 person age 65 or over, or a blind or disabled person, who would
257 be eligible under any group listed in s. 409.903(1), (2), or
258 (3), except that the income or assets of such family or person
259 exceed established limitations. For a family or person in one of
260 these coverage groups, medical expenses are deductible from
261 income in accordance with federal requirements in order to make

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262 a determination of eligibility. A family or person eligible
263 under the coverage known as the "medically needy," is eligible
264 to receive the same services as other Medicaid recipients, with
265 the exception of services in skilled nursing facilities and
266 intermediate care facilities for the developmentally disabled.
267 Effective July 1, 2005, the medically needy are eligible for
268 prescribed drug services only.
269 (3) A person who is in need of the services of a licensed
270 nursing facility, a licensed intermediate care facility for the
271 developmentally disabled, or a state mental hospital, whose
272 income does not exceed 300 percent of the SSI income standard,
273 and who meets the assets standards established under federal and
274 state law. In determining the person's responsibility for the
275 cost of care, the following amounts must be deducted from the
276 person's income:
277 (a) The monthly personal allowance for residents as set
278 based on appropriations.
279 (b) The reasonable costs of medically necessary services
280 and supplies that are not reimbursable by the Medicaid program.
281 (c) The cost of premiums, copayments, coinsurance, and
282 deductibles for supplemental health insurance.
283 Section 8. Subsections (4), (5), and (8) of section
284 409.905, Florida Statutes, are amended to read:
285 409.905 Mandatory Medicaid services.--The agency may make
286 payments for the following services, which are required of the
287 state by Title XIX of the Social Security Act, furnished by
288 Medicaid providers to recipients who are determined to be
289 eligible on the dates on which the services were provided. Any
290 service under this section shall be provided only when medically

291 necessary and in accordance with state and federal law.
292 Mandatory services rendered by providers in mobile units to
293 Medicaid recipients may be restricted by the agency. Nothing in
294 this section shall be construed to prevent or limit the agency
295 from adjusting fees, reimbursement rates, lengths of stay,
296 number of visits, number of services, or any other adjustments
297 necessary to comply with the availability of moneys and any
298 limitations or directions provided for in the General
299 Appropriations Act or chapter 216.
300 (4) HOME HEALTH CARE SERVICES.--The agency shall pay for
301 nursing and home health aide services, supplies, appliances, and
302 durable medical equipment, necessary to assist a recipient
303 living at home. An entity that provides services pursuant to
304 this subsection shall be licensed under part IV of chapter 400
305 ~~or part II of chapter 499, if appropriate~~. These services,
306 equipment, and supplies, or reimbursement therefor, may be
307 limited as provided in the General Appropriations Act and do not
308 include services, equipment, or supplies provided to a person
309 residing in a hospital or nursing facility.
310 (a) In providing home health care services, the agency may
311 require prior authorization of care based on diagnosis.
312 (b) The agency shall implement a comprehensive utilization
313 management program that requires prior authorization of all
314 private duty nursing services, an individualized treatment plan
315 that includes information about medication and treatment orders,
316 treatment goals, methods of care to be used, and plans for care
317 coordination by nurses and other health professionals. The
318 utilization management program shall also include a process for
319 periodically reviewing the ongoing use of private duty nursing

320 services. The assessment of need shall be based on a child's
321 condition, family support and care supplements, a family's
322 ability to provide care, and a family's and child's schedule
323 regarding work, school, sleep, and care for other family
324 dependents. When implemented, the private duty nursing
325 utilization management program shall replace the current
326 authorization program used by the Agency for Health Care
327 Administration and the Children's Medical Services program of
328 the Department of Health. The agency may competitively bid on a
329 contract to select a qualified organization to provide
330 utilization management of private duty nursing services. The
331 agency is authorized to seek federal waivers to implement this
332 initiative.

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

341 (a) The agency is authorized to implement reimbursement
342 and utilization management reforms in order to comply with any
343 limitations or directions in the General Appropriations Act,
344 which may include, but are not limited to: prior authorization
345 for inpatient psychiatric days; prior authorization for
346 nonemergency hospital inpatient admissions for individuals 21
347 years of age and older; authorization of emergency and urgent-
348 care admissions within 24 hours after admission; enhanced

349 utilization and concurrent review programs for highly utilized
350 services; reduction or elimination of covered days of service;
351 adjusting reimbursement ceilings for variable costs; adjusting
352 reimbursement ceilings for fixed and property costs; and
353 implementing target rates of increase. The agency may limit
354 prior authorization for hospital inpatient services to selected
355 diagnosis-related groups, based on an analysis of the cost and
356 potential for unnecessary hospitalizations represented by
357 certain diagnoses. Admissions for normal delivery and newborns
358 are exempt from requirements for prior authorization. In
359 implementing the provisions of this section related to prior
360 authorization, the agency shall ensure that the process for
361 authorization is accessible 24 hours per day, 7 days per week
362 and authorization is automatically granted when not denied
363 within 4 hours after the request. Authorization procedures must
364 include steps for review of denials. Upon implementing the prior
365 authorization program for hospital inpatient services, the
366 agency shall discontinue its hospital retrospective review
367 program.
368 (b) A licensed hospital maintained primarily for the care
369 and treatment of patients having mental disorders or mental
370 diseases is not eligible to participate in the hospital
371 inpatient portion of the Medicaid program except as provided in
372 federal law. However, the department shall apply for a waiver,
373 within 9 months after June 5, 1991, designed to provide
374 hospitalization services for mental health reasons to children
375 and adults in the most cost-effective and lowest cost setting
376 possible. Such waiver shall include a request for the
377 opportunity to pay for care in hospitals known under federal law

378 as "institutions for mental disease" or "IMD's." The waiver
379 proposal shall propose no additional aggregate cost to the state
380 or Federal Government, and shall be conducted in Hillsborough
381 County, Highlands County, Hardee County, Manatee County, and
382 Polk County. The waiver proposal may incorporate competitive
383 bidding for hospital services, comprehensive brokering, prepaid
384 capitated arrangements, or other mechanisms deemed by the
385 department to show promise in reducing the cost of acute care
386 and increasing the effectiveness of preventive care. When
387 developing the waiver proposal, the department shall take into
388 account price, quality, accessibility, linkages of the hospital
389 to community services and family support programs, plans of the
390 hospital to ensure the earliest discharge possible, and the
391 comprehensiveness of the mental health and other health care
392 services offered by participating providers.
393 (c) The Agency for Health Care Administration shall adjust
394 a hospital's current inpatient per diem rate to reflect the cost
395 of serving the Medicaid population at that institution if:
396 1. The hospital experiences an increase in Medicaid
397 caseload by more than 25 percent in any year, primarily
398 resulting from the closure of a hospital in the same service
399 area occurring after July 1, 1995;
400 2. The hospital's Medicaid per diem rate is at least 25
401 percent below the Medicaid per patient cost for that year; or
402 3. The hospital is located in a county that has five or
403 fewer hospitals, began offering obstetrical services on or after
404 September 1999, and has submitted a request in writing to the
405 agency for a rate adjustment after July 1, 2000, but before
406 September 30, 2000, in which case such hospital's Medicaid

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407 inpatient per diem rate shall be adjusted to cost, effective
408 July 1, 2002.
409
410 No later than October 1 of each year, the agency must provide
411 estimated costs for any adjustment in a hospital inpatient per
412 diem pursuant to this paragraph to the Executive Office of the
413 Governor, the House of Representatives General Appropriations
414 Committee, and the Senate Appropriations Committee. Before the
415 agency implements a change in a hospital's inpatient per diem
416 rate pursuant to this paragraph, the Legislature must have
417 specifically appropriated sufficient funds in the General
418 Appropriations Act to support the increase in cost as estimated
419 by the agency.
420 (d) The agency shall implement a hospitalist program in
421 certain high-volume participating hospitals, select counties, or
422 statewide. The program shall require hospitalists to authorize
423 and manage Medicaid recipients' hospital admissions and lengths
424 of stay. Individuals who are dually eligible for Medicare and
425 Medicaid are exempted from this requirement. Medicaid
426 participating physicians and other practitioners with hospital
427 admitting privileges shall coordinate and review admissions of
428 Medicaid recipients with the hospitalist. The agency may
429 competitively bid a contract for selection of a qualified
430 organization to provide hospitalist services. The qualified
431 organization shall employ board certified physicians who are
432 full-time dedicated employees of the contractor and have no
433 outside practice. Where used, the hospitalist program shall
434 replace the existing hospital utilization review program. The
435 agency is authorized to seek federal waivers to implement this

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436 program.

437 (e) The agency shall implement a comprehensive utilization
438 management program for hospital neonatal intensive care stays in
439 certain high-volume participating hospitals, select counties, or
440 statewide, and shall replace existing hospital inpatient
441 utilization management programs for neonatal intensive care
442 admissions. The program shall be designed to manage the lengths
443 of stay for children being treated in neonatal intensive care
444 units and must seek the earliest medically appropriate discharge
445 to the child's home or other less costly treatment setting. The
446 agency may competitively bid a contract for selection of a
447 qualified organization to provide neonatal intensive care
448 utilization management services. The agency is authorized to
449 seek any federal waivers to implement this initiative.

450 (8) NURSING FACILITY SERVICES.--The agency shall pay for
451 24-hour-a-day nursing and rehabilitative services for a
452 recipient in a nursing facility licensed under part II of
453 chapter 400 or in a rural hospital, as defined in s. 395.602, or
454 in a Medicare certified skilled nursing facility operated by a
455 hospital, as defined by s. 395.002(11), that is licensed under
456 part I of chapter 395, and in accordance with provisions set
457 forth in s. 409.908(2)(a), which services are ordered by and
458 provided under the direction of a licensed physician. However,
459 if a nursing facility has been destroyed or otherwise made
460 uninhabitable by natural disaster or other emergency and another
461 nursing facility is not available, the agency must pay for
462 similar services temporarily in a hospital licensed under part I
463 of chapter 395 provided federal funding is approved and
464 available. The agency shall pay only for bed hold days if the

465 facility has an occupancy rate of 95 percent or greater. The
466 agency is authorized to seek any federal waivers to implement
467 this policy.
468 Section 9. Subsections (1), (13), and (15) of section
469 409.906, Florida Statutes, are amended to read:
470 409.906 Optional Medicaid services.--Subject to specific
471 appropriations, the agency may make payments for services which
472 are optional to the state under Title XIX of the Social Security
473 Act and are furnished by Medicaid providers to recipients who
474 are determined to be eligible on the dates on which the services
475 were provided. Any optional service that is provided shall be
476 provided only when medically necessary and in accordance with
477 state and federal law. Optional services rendered by providers
478 in mobile units to Medicaid recipients may be restricted or
479 prohibited by the agency. Nothing in this section shall be
480 construed to prevent or limit the agency from adjusting fees,
481 reimbursement rates, lengths of stay, number of visits, or
482 number of services, or making any other adjustments necessary to
483 comply with the availability of moneys and any limitations or
484 directions provided for in the General Appropriations Act or
485 chapter 216. If necessary to safeguard the state's systems of
486 providing services to elderly and disabled persons and subject
487 to the notice and review provisions of s. 216.177, the Governor
488 may direct the Agency for Health Care Administration to amend
489 the Medicaid state plan to delete the optional Medicaid service
490 known as "Intermediate Care Facilities for the Developmentally
491 Disabled." Optional services may include:
492 (1) ADULT DENTAL SERVICES.--
493 (a) The agency may pay for medically necessary, emergency

494 dental procedures to alleviate pain or infection. Emergency
495 dental care shall be limited to emergency oral examinations,
496 necessary radiographs, extractions, and incision and drainage of
497 abscess, for a recipient who is ~~age~~ 21 years of age or older.
498 (b) Beginning January 1, 2005, the agency may pay for
499 dentures, the procedures required to seat dentures, and the
500 repair and reline of dentures, provided by or under the
501 direction of a licensed dentist, for a recipient who is 21 years
502 of age or older. This paragraph is repealed effective July 1,
503 2005.
504 (c) However, Medicaid will not provide reimbursement for
505 dental services provided in a mobile dental unit, except for a
506 mobile dental unit:
507 1.~~(a)~~ Owned by, operated by, or having a contractual
508 agreement with the Department of Health and complying with
509 Medicaid's county health department clinic services program
510 specifications as a county health department clinic services
511 provider.
512 2.~~(b)~~ Owned by, operated by, or having a contractual
513 arrangement with a federally qualified health center and
514 complying with Medicaid's federally qualified health center
515 specifications as a federally qualified health center provider.
516 3.~~(c)~~ Rendering dental services to Medicaid recipients, 21
517 years of age and older, at nursing facilities.
518 4.~~(d)~~ Owned by, operated by, or having a contractual
519 agreement with a state-approved dental educational institution.
520 (13) HOME AND COMMUNITY-BASED SERVICES.--
521 (a) The agency may pay for home-based or community-based
522 services that are rendered to a recipient in accordance with a

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523 federally approved waiver program. The agency may limit or
524 eliminate coverage for certain Project AIDS Care Waiver
525 services, preauthorize high-cost or highly utilized services, or
526 make any other adjustments necessary to comply with any
527 limitations or directions provided for in the General
528 Appropriations Act.
529 (b) The agency may consolidate types of services offered
530 in the Aged and Disabled Waiver, the Channeling Waiver, the
531 Project AIDS Care Waiver, and the Traumatic Brain and Spinal
532 Cord Injury Waiver programs in order to group similar services
533 under a single service, or continue a service upon evidence of
534 the need for including a particular service type in a particular
535 waiver. The agency is authorized to seek a Medicaid state plan
536 amendment or federal waiver approval to implement this policy.
537 (c) The agency may implement a utilization management
538 program designed to prior authorize home and community-based
539 service plans and includes, but is not limited to, assessing
540 proposed quantity and duration of services and monitoring
541 ongoing service use by participants in the program. The agency
542 is authorized to competitively procure a qualified organization
543 to provide utilization management of home and community-based
544 services. The agency is authorized to seek any federal waivers
545 to implement this initiative.
546 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY
547 DISABLED SERVICES.--The agency may pay for health-related care
548 and services provided on a 24-hour-a-day basis by a facility
549 licensed and certified as a Medicaid Intermediate Care Facility
550 for the Developmentally Disabled, for a recipient who needs such
551 care because of a developmental disability. Payment shall not

552 include bed-hold days except in facilities with occupancy rates
553 of 95 percent or greater. The agency is authorized to seek any
554 federal waiver approvals to implement this policy.
555 Section 10. Subsection (8) of section 409.9065, Florida
556 Statutes, is renumbered as subsection (9), and a new subsection
557 (8) is added to said section, to read:
558 409.9065 Pharmaceutical expense assistance.--
559 (8) PHARMACEUTICAL EXPENSE ASSISTANCE PROGRAM.--In the
560 absence of federal approval for the Lifesaver Rx Program to
561 provide benefits to higher income groups and additional
562 discounts as described in subsections (2) and (3), the Agency
563 for Health Care Administration may, subject to federal approval
564 and continuing state appropriations, operate a pharmaceutical
565 expense assistance program that limits eligibility and benefits
566 to Medicaid beneficiaries who do not normally receive Medicaid
567 benefits, are Florida residents age 65 and older, have an income
568 less than or equal to 120 percent of the federal poverty level,
569 are eligible for Medicare, and request to be enrolled in the
570 program. Benefits under the limited pharmaceutical expense
571 assistance program shall include Medicaid payment for up to $160
572 per month for prescribed drugs, subject to benefit utilization
573 controls applied to other Medicaid prescribed drug benefits and
574 the following copayments: $2 per generic product, $5 for a
575 product that is on the Medicaid Preferred Drug List, and $15 for
576 a product that is not on the preferred drug list.
577 Section 11. Subsection (12) is added to section 409.907,
578 Florida Statutes, to read:
579 409.907 Medicaid provider agreements.--The agency may make
580 payments for medical assistance and related services rendered to

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581 Medicaid recipients only to an individual or entity who has a
582 provider agreement in effect with the agency, who is performing
583 services or supplying goods in accordance with federal, state,
584 and local law, and who agrees that no person shall, on the
585 grounds of handicap, race, color, or national origin, or for any
586 other reason, be subjected to discrimination under any program
587 or activity for which the provider receives payment from the
588 agency.

589 (12) Licensed, certified, or otherwise qualified providers
590 are not entitled to enrollment in a Medicaid provider network.

591 Section 12. Subsections (4), (14), and (19) of section
592 409.908, Florida Statutes, are amended to read:

593 409.908 Reimbursement of Medicaid providers.--Subject to
594 specific appropriations, the agency shall reimburse Medicaid
595 providers, in accordance with state and federal law, according
596 to methodologies set forth in the rules of the agency and in
597 policy manuals and handbooks incorporated by reference therein.
598 These methodologies may include fee schedules, reimbursement
599 methods based on cost reporting, negotiated fees, competitive
600 bidding pursuant to s. 287.057, and other mechanisms the agency
601 considers efficient and effective for purchasing services or
602 goods on behalf of recipients. If a provider is reimbursed based
603 on cost reporting and submits a cost report late and that cost
604 report would have been used to set a lower reimbursement rate
605 for a rate semester, then the provider's rate for that semester
606 shall be retroactively calculated using the new cost report, and
607 full payment at the recalculated rate shall be affected
608 retroactively. Medicare-granted extensions for filing cost
609 reports, if applicable, shall also apply to Medicaid cost

610 reports. Payment for Medicaid compensable services made on
611 behalf of Medicaid eligible persons is subject to the
612 availability of moneys and any limitations or directions
613 provided for in the General Appropriations Act or chapter 216.
614 Further, nothing in this section shall be construed to prevent
615 or limit the agency from adjusting fees, reimbursement rates,
616 lengths of stay, number of visits, or number of services, or
617 making any other adjustments necessary to comply with the
618 availability of moneys and any limitations or directions
619 provided for in the General Appropriations Act, provided the
620 adjustment is consistent with legislative intent.
621 (4) Subject to any limitations or directions provided for
622 in the General Appropriations Act, alternative health plans,
623 health maintenance organizations, and prepaid health plans shall
624 be reimbursed a fixed, prepaid amount negotiated, or
625 competitively bid pursuant to s. 287.057, by the agency and
626 prospectively paid to the provider monthly for each Medicaid
627 recipient enrolled. The amount may not exceed the average amount
628 the agency determines it would have paid, based on claims
629 experience, for recipients in the same or similar category of
630 eligibility. The agency shall calculate capitation rates on a
631 regional basis and, beginning September 1, 1995, shall include
632 age-band differentials in such calculations. ~~Effective July 1,~~
633 ~~2001, the cost of exempting statutory teaching hospitals,~~
634 ~~specialty hospitals, and community hospital education program~~
635 ~~hospitals from reimbursement ceilings and the cost of special~~
636 ~~Medicaid payments shall not be included in premiums paid to~~
637 ~~health maintenance organizations or prepaid health care plans.~~
638 ~~Each rate semester, the agency shall calculate and publish a~~

639 ~~Medicaid hospital rate schedule that does not reflect either~~
640 ~~special Medicaid payments or the elimination of rate~~
641 ~~reimbursement ceilings, to be used by hospitals and Medicaid~~
642 ~~health maintenance organizations, in order to determine the~~
643 ~~Medicaid rate referred to in ss. 409.912(17), 409.9128(5), and~~
644 ~~641.513(6).~~
645 (14) A provider of prescribed drugs shall be reimbursed
646 the least of the amount billed by the provider, the provider's
647 usual and customary charge, or the Medicaid maximum allowable
648 fee established by the agency, plus a dispensing fee. The
649 Medicaid maximum allowable fee for ingredient cost will be based
650 on the lower of: average wholesale price (AWP) minus 15.4
651 percent, wholesaler acquisition cost (WAC) plus 5.75 percent,
652 the federal upper limit (FUL), the state maximum allowable cost
653 (SMAC), or the usual and customary (UAC) charge billed by the
654 provider. Medicaid providers are required to dispense generic
655 drugs if available at lower cost and the agency has not
656 determined that the branded product is more cost-effective,
657 unless the prescriber has requested and received approval to
658 require the branded product. The agency is directed to implement
659 a variable dispensing fee for payments for prescribed medicines
660 while ensuring continued access for Medicaid recipients. The
661 variable dispensing fee may be based upon, but not limited to,
662 either or both the volume of prescriptions dispensed by a
663 specific pharmacy provider, the volume of prescriptions
664 dispensed to an individual recipient, and dispensing of
665 preferred-drug-list products. The agency may increase the
666 pharmacy dispensing fee authorized by statute and in the annual
667 General Appropriations Act by $0.50 for the dispensing of a

668 Medicaid preferred-drug-list product and reduce the pharmacy
669 dispensing fee by $0.50 for the dispensing of a Medicaid product
670 that is not included on the preferred-drug list. The agency may
671 establish a supplemental pharmaceutical dispensing fee to be
672 paid to providers returning unused unit-dose packaged
673 medications to stock and crediting the Medicaid program for the
674 ingredient cost of those medications if the ingredient costs to
675 be credited exceed the value of the supplemental dispensing fee.
676 The agency is authorized to limit reimbursement for prescribed
677 medicine in order to comply with any limitations or directions
678 provided for in the General Appropriations Act, which may
679 include implementing a prospective or concurrent utilization
680 review program.
681 (19) County health department services shall ~~may~~ be
682 reimbursed a rate per visit based on total reasonable costs of
683 the clinic, as determined by the agency in accordance with
684 federal regulations under the authority of 42 C.F.R. s. 431.615.
685 Section 13. Section 409.911, Florida Statutes, is amended
686 to read:
687 409.911 Disproportionate share program.--Subject to
688 specific allocations established within the General
689 Appropriations Act and any limitations established pursuant to
690 chapter 216, the agency shall distribute, pursuant to this
691 section, moneys to hospitals providing a disproportionate share
692 of Medicaid or charity care services by making quarterly
693 Medicaid payments as required. Notwithstanding the provisions of
694 s. 409.915, counties are exempt from contributing toward the
695 cost of this special reimbursement for hospitals serving a
696 disproportionate share of low-income patients.

697 (1) Definitions.--As used in this section, s. 409.9112,
698 and the Florida Hospital Uniform Reporting System manual:
699 (a) "Adjusted patient days" means the sum of acute care
700 patient days and intensive care patient days as reported to the
701 Agency for Health Care Administration, divided by the ratio of
702 inpatient revenues generated from acute, intensive, ambulatory,
703 and ancillary patient services to gross revenues.
704 (b) "Actual audited data" or "actual audited experience"
705 means data reported to the Agency for Health Care Administration
706 which has been audited in accordance with generally accepted
707 auditing standards by the agency or representatives under
708 contract with the agency.
709 (c) "Charity care" or "uncompensated charity care" means
710 that portion of hospital charges reported to the Agency for
711 Health Care Administration for which there is no compensation,
712 other than restricted or unrestricted revenues provided to a
713 hospital by local governments or tax districts regardless of the
714 method of payment, for care provided to a patient whose family
715 income for the 12 months preceding the determination is less
716 than or equal to 200 percent of the federal poverty level,
717 unless the amount of hospital charges due from the patient
718 exceeds 25 percent of the annual family income. However, in no
719 case shall the hospital charges for a patient whose family
720 income exceeds four times the federal poverty level for a family
721 of four be considered charity.
722 (d) "Charity care days" means the sum of the deductions
723 from revenues for charity care minus 50 percent of restricted
724 and unrestricted revenues provided to a hospital by local
725 governments or tax districts, divided by gross revenues per

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726 adjusted patient day.
727 (e) "Hospital" means a health care institution licensed as
728 a hospital pursuant to chapter 395, but does not include
729 ambulatory surgical centers.
730 (f) "Medicaid days" means the number of actual days
731 attributable to Medicaid patients as determined by the Agency
732 for Health Care Administration.
733 (2) The Agency for Health Care Administration shall use
734 the following actual audited data to determine the Medicaid days
735 and charity care to be used in calculating the disproportionate
736 share payment:
737 (a) The average of the ~~1997~~, 1998, ~~and~~ 1999, and 2000
738 audited data to determine each hospital's Medicaid days and
739 charity care.
740 (b) The average of the audited disproportionate share data
741 for the years available if the Agency for Health Care
742 Administration does not have the prescribed 3 years of audited
743 disproportionate share data for a hospital.
744 (c) In accordance with s. 1923(b) of the Social Security
745 Act, a hospital with a Medicaid inpatient utilization rate
746 greater than one standard deviation above the statewide mean or
747 a hospital with a low-income utilization rate of 25 percent or
748 greater shall qualify for reimbursement.
749 (3) Hospitals that qualify for a disproportionate share
750 payment solely under paragraph (2)(c) shall have their payment
751 calculated in accordance with the following formulas:
752
753 DSHP = (HMD/TMSD) x $1 million
754

755 Where:
756 DSHP = disproportionate share hospital payment.
757 HMD = hospital Medicaid days.
758 TSD = total state Medicaid days.
759
760 Any funds not allocated to hospitals qualifying under this
761 section shall be redistributed to the non-state government owned
762 or operated hospitals with greater than 3,300 Medicaid days.
763 (4) The following formulas shall be used to pay
764 disproportionate share dollars to public hospitals:
765 (a) For state mental health hospitals:
766

767 $$DSHP = (HMD/TMDMH) \times TAAMH$$

768
769 shall be the difference between the federal cap for
770 Institutions for Mental Diseases and the amounts paid under the
771 mental health disproportionate share program.
772
773 Where:
774 DSHP = disproportionate share hospital payment.
775 HMD = hospital Medicaid days.
776 TMDHH = total Medicaid days for state mental health
777 hospitals.
778 TAAMH = total amount available for mental health hospitals.
779
780 (b) For non-state government owned or operated hospitals
781 with 3,300 or more Medicaid days:
782

783 $$DSHP = [(.82 \times HCCD/TCCD) + (.18 \times HMD/TMD)]$$

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784 x TAAPH

785 TAAPH = TAA - TAAMH

786

787 Where:

788 TAA = total available appropriation.

789 TAAPH = total amount available for public hospitals.

790 DSHP = disproportionate share hospital payments.

791 HMD = hospital Medicaid days.

792 TMD = total state Medicaid days for public hospitals.

793 HCCD = hospital charity care dollars.

794 TCCD = total state charity care dollars for public non-

795 state hospitals.

796

797 The TAAPH shall be reduced by $6,365,257 before computing the

798 DSHP for each public hospital. The $6,365,257 shall be

799 distributed equally between the public hospitals that are also

800 designated statutory teaching hospitals.

801 (c) For non-state government owned or operated hospitals

802 with less than 3,300 Medicaid days, a total of $750,000 ~~$400,000~~

803 shall be distributed equally among these hospitals.

804 (5) In no case shall total payments to a hospital under

805 this section, with the exception of public non-state facilities

806 or state facilities, exceed the total amount of uncompensated

807 charity care of the hospital, as determined by the agency

808 according to the most recent calendar year audited data

809 available at the beginning of each state fiscal year.

810 (6) The agency is authorized to receive funds from local

811 governments and other local political subdivisions for the

812 purpose of making payments, including federal matching funds,

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813 through the Medicaid disproportionate share program. Funds
814 received from local governments for this purpose shall be
815 separately accounted for and shall not be commingled with other
816 state or local funds in any manner.
817 (7) Payments made by the agency to hospitals eligible to
818 participate in this program shall be made in accordance with
819 federal rules and regulations.
820 (a) If the Federal Government prohibits, restricts, or
821 changes in any manner the methods by which funds are distributed
822 for this program, the agency shall not distribute any additional
823 funds and shall return all funds to the local government from
824 which the funds were received, except as provided in paragraph
825 (b).
826 (b) If the Federal Government imposes a restriction that
827 still permits a partial or different distribution, the agency
828 may continue to disburse funds to hospitals participating in the
829 disproportionate share program in a federally approved manner,
830 provided:
831 1. Each local government which contributes to the
832 disproportionate share program agrees to the new manner of
833 distribution as shown by a written document signed by the
834 governing authority of each local government; and
835 2. The Executive Office of the Governor, the Office of
836 Planning and Budgeting, the House of Representatives, and the
837 Senate are provided at least 7 days' prior notice of the
838 proposed change in the distribution, and do not disapprove such
839 change.
840 (c) No distribution shall be made under the alternative
841 method specified in paragraph (b) unless all parties agree or

842 unless all funds of those parties that disagree which are not
843 yet disbursed have been returned to those parties.
844 (8) Notwithstanding the provisions of chapter 216, the
845 Executive Office of the Governor is hereby authorized to
846 establish sufficient trust fund authority to implement the
847 disproportionate share program.
848 (9) The Agency for Health Care Administration shall create
849 a Medicaid Disproportionate Share Council.
850 (a) The purpose of the council is to study and make
851 recommendations regarding:
852 1. The formula for the regular disproportionate share
853 program and alternative financing options.
854 2. Enhanced Medicaid funding through the Special Medicaid
855 Payment program.
856 3. The federal status of the upper-payment-limit funding
857 option and how this option may be used to promote health care
858 initiatives determined by the council to be state health care
859 priorities.
860 (b) The council shall include representatives of the
861 Executive Office of the Governor and of the agency;
862 representatives from teaching, public, private nonprofit,
863 private for-profit and family practice teaching hospitals; and
864 representatives from other groups as needed.
865 (c) The council shall submit its findings and
866 recommendations to the Governor and the Legislature no later
867 than February 1 of each year.
868 Section 14. Section 409.9112, Florida Statutes, is amended
869 to read:
870 409.9112 Disproportionate share program for regional

871 perinatal intensive care centers.--In addition to the payments
872 made under s. 409.911, the Agency for Health Care Administration
873 shall design and implement a system of making disproportionate
874 share payments to those hospitals that participate in the
875 regional perinatal intensive care center program established
876 pursuant to chapter 383. This system of payments shall conform
877 with federal requirements and shall distribute funds in each
878 fiscal year for which an appropriation is made by making
879 quarterly Medicaid payments. Notwithstanding the provisions of
880 s. 409.915, counties are exempt from contributing toward the
881 cost of this special reimbursement for hospitals serving a
882 disproportionate share of low-income patients. For the state
883 fiscal year 2004-2005, the agency shall not distribute moneys
884 under the regional perinatal intensive care centers
885 disproportionate share program, except as noted in subsection
886 (2). In the event the Centers for Medicare and Medicaid Services
887 do not approve Florida's inpatient hospital state plan amendment
888 for the public disproportionate share program by January 1,
889 2005, the agency may make payments to hospitals under the
890 regional perinatal intensive care centers disproportionate share
891 program.
892 (1) The following formula shall be used by the agency to
893 calculate the total amount earned for hospitals that participate
894 in the regional perinatal intensive care center program:
895
896 TAE = HDSP/THDSP
897
898 Where:
899 TAE = total amount earned by a regional perinatal intensive

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900 care center.

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

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

907

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

911

912 TAP = TAE x TA

913

914 Where:

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

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

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

921

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

926 (a) Agree to conform to all departmental and agency
927 requirements to ensure high quality in the provision of
928 services, including criteria adopted by departmental and agency

929 rule concerning staffing ratios, medical records, standards of
930 care, equipment, space, and such other standards and criteria as
931 the department and agency deem appropriate as specified by rule.
932 (b) Agree to provide information to the department and
933 agency, in a form and manner to be prescribed by rule of the
934 department and agency, concerning the care provided to all
935 patients in neonatal intensive care centers and high-risk
936 maternity care.
937 (c) Agree to accept all patients for neonatal intensive
938 care and high-risk maternity care, regardless of ability to pay,
939 on a functional space-available basis.
940 (d) Agree to develop arrangements with other maternity and
941 neonatal care providers in the hospital's region for the
942 appropriate receipt and transfer of patients in need of
943 specialized maternity and neonatal intensive care services.
944 (e) Agree to establish and provide a developmental
945 evaluation and services program for certain high-risk neonates,
946 as prescribed and defined by rule of the department.
947 (f) Agree to sponsor a program of continuing education in
948 perinatal care for health care professionals within the region
949 of the hospital, as specified by rule.
950 (g) Agree to provide backup and referral services to the
951 department's county health departments and other low-income
952 perinatal providers within the hospital's region, including the
953 development of written agreements between these organizations
954 and the hospital.
955 (h) Agree to arrange for transportation for high-risk
956 obstetrical patients and neonates in need of transfer from the
957 community to the hospital or from the hospital to another more

958 appropriate facility.
959 (4) Hospitals which fail to comply with any of the
960 conditions in subsection (3) or the applicable rules of the
961 department and agency shall not receive any payments under this
962 section until full compliance is achieved. A hospital which is
963 not in compliance in two or more consecutive quarters shall not
964 receive its share of the funds. Any forfeited funds shall be
965 distributed by the remaining participating regional perinatal
966 intensive care center program hospitals.
967 Section 15. Section 409.9113, Florida Statutes, is amended
968 to read:
969 409.9113 Disproportionate share program for teaching
970 hospitals.--In addition to the payments made under ss. 409.911
971 and 409.9112, the Agency for Health Care Administration shall
972 make disproportionate share payments to statutorily defined
973 teaching hospitals for their increased costs associated with
974 medical education programs and for tertiary health care services
975 provided to the indigent. This system of payments shall conform
976 with federal requirements and shall distribute funds in each
977 fiscal year for which an appropriation is made by making
978 quarterly Medicaid payments. Notwithstanding s. 409.915,
979 counties are exempt from contributing toward the cost of this
980 special reimbursement for hospitals serving a disproportionate
981 share of low-income patients. For the state fiscal year 2004-
982 2005, the agency shall not distribute moneys under the teaching
983 hospital disproportionate share program, except as noted in
984 subsection (2). In the event the Centers for Medicare and
985 Medicaid Services do not approve Florida's inpatient hospital
986 state plan amendment for the public disproportionate share

987 program by January 1, 2005, the agency may make payments to
988 hospitals under the teaching hospital disproportionate share
989 program.
990 (1) On or before September 15 of each year, the Agency for
991 Health Care Administration shall calculate an allocation
992 fraction to be used for distributing funds to state statutory
993 teaching hospitals. Subsequent to the end of each quarter of the
994 state fiscal year, the agency shall distribute to each statutory
995 teaching hospital, as defined in s. 408.07, an amount determined
996 by multiplying one-fourth of the funds appropriated for this
997 purpose by the Legislature times such hospital's allocation
998 fraction. The allocation fraction for each such hospital shall
999 be determined by the sum of three primary factors, divided by
1000 three. The primary factors are:
1001 (a) The number of nationally accredited graduate medical
1002 education programs offered by the hospital, including programs
1003 accredited by the Accreditation Council for Graduate Medical
1004 Education and the combined Internal Medicine and Pediatrics
1005 programs acceptable to both the American Board of Internal
1006 Medicine and the American Board of Pediatrics at the beginning
1007 of the state fiscal year preceding the date on which the
1008 allocation fraction is calculated. The numerical value of this
1009 factor is the fraction that the hospital represents of the total
1010 number of programs, where the total is computed for all state
1011 statutory teaching hospitals.
1012 (b) The number of full-time equivalent trainees in the
1013 hospital, which comprises two components:
1014 1. The number of trainees enrolled in nationally
1015 accredited graduate medical education programs, as defined in

1016 paragraph (a). Full-time equivalents are computed using the
1017 fraction of the year during which each trainee is primarily
1018 assigned to the given institution, over the state fiscal year
1019 preceding the date on which the allocation fraction is
1020 calculated. The numerical value of this factor is the fraction
1021 that the hospital represents of the total number of full-time
1022 equivalent trainees enrolled in accredited graduate programs,
1023 where the total is computed for all state statutory teaching
1024 hospitals.
1025 2. The number of medical students enrolled in accredited
1026 colleges of medicine and engaged in clinical activities,
1027 including required clinical clerkships and clinical electives.
1028 Full-time equivalents are computed using the fraction of the
1029 year during which each trainee is primarily assigned to the
1030 given institution, over the course of the state fiscal year
1031 preceding the date on which the allocation fraction is
1032 calculated. The numerical value of this factor is the fraction
1033 that the given hospital represents of the total number of full-
1034 time equivalent students enrolled in accredited colleges of
1035 medicine, where the total is computed for all state statutory
1036 teaching hospitals.
1037
1038 The primary factor for full-time equivalent trainees is computed
1039 as the sum of these two components, divided by two.
1040 (c) A service index that comprises three components:
1041 1. The Agency for Health Care Administration Service
1042 Index, computed by applying the standard Service Inventory
1043 Scores established by the Agency for Health Care Administration
1044 to services offered by the given hospital, as reported on

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1045 Worksheet A-2 for the last fiscal year reported to the agency
1046 before the date on which the allocation fraction is calculated.
1047 The numerical value of this factor is the fraction that the
1048 given hospital represents of the total Agency for Health Care
1049 Administration Service Index values, where the total is computed
1050 for all state statutory teaching hospitals.
1051 2. A volume-weighted service index, computed by applying
1052 the standard Service Inventory Scores established by the Agency
1053 for Health Care Administration to the volume of each service,
1054 expressed in terms of the standard units of measure reported on
1055 Worksheet A-2 for the last fiscal year reported to the agency
1056 before the date on which the allocation factor is calculated.
1057 The numerical value of this factor is the fraction that the
1058 given hospital represents of the total volume-weighted service
1059 index values, where the total is computed for all state
1060 statutory teaching hospitals.
1061 3. Total Medicaid payments to each hospital for direct
1062 inpatient and outpatient services during the fiscal year
1063 preceding the date on which the allocation factor is calculated.
1064 This includes payments made to each hospital for such services
1065 by Medicaid prepaid health plans, whether the plan was
1066 administered by the hospital or not. The numerical value of this
1067 factor is the fraction that each hospital represents of the
1068 total of such Medicaid payments, where the total is computed for
1069 all state statutory teaching hospitals.
1070
1071 The primary factor for the service index is computed as the sum
1072 of these three components, divided by three.
1073 (2) By October 1 of each year, the agency shall use the

1074 following formula to calculate the maximum additional
1075 disproportionate share payment for statutorily defined teaching
1076 hospitals:
1077
1078 TAP = THAF x A
1079
1080 Where:
1081 TAP = total additional payment.
1082 THAF = teaching hospital allocation factor.
1083 A = amount appropriated for a teaching hospital
1084 disproportionate share program.
1085 Section 16. Section 409.9117, Florida Statutes, is amended
1086 to read:
1087 409.9117 Primary care disproportionate share program.--
1088 For the state fiscal year 2004-2005, the agency shall not
1089 distribute moneys under the primary care disproportionate share
1090 program, except as noted in subsection (2). In the event the
1091 Centers for Medicare and Medicaid Services do not approve
1092 Florida's inpatient hospital state plan amendment for the public
1093 disproportionate share program by January 1, 2005, the agency
1094 may make payments to hospitals under the primary care
1095 disproportionate share program.
1096 (1) If federal funds are available for disproportionate
1097 share programs in addition to those otherwise provided by law,
1098 there shall be created a primary care disproportionate share
1099 program.
1100 (2) The following formula shall be used by the agency to
1101 calculate the total amount earned for hospitals that participate
1102 in the primary care disproportionate share program:

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

1132 (b) Ensure the availability of primary and specialty care
1133 physicians to Medicaid recipients who are not enrolled in a
1134 prepaid capitated arrangement and who are in need of access to
1135 such physicians.
1136 (c) Coordinate and provide primary care services free of
1137 charge, except copayments, to all persons with incomes up to 100
1138 percent of the federal poverty level who are not otherwise
1139 covered by Medicaid or another program administered by a
1140 governmental entity, and to provide such services based on a
1141 sliding fee scale to all persons with incomes up to 200 percent
1142 of the federal poverty level who are not otherwise covered by
1143 Medicaid or another program administered by a governmental
1144 entity, except that eligibility may be limited to persons who
1145 reside within a more limited area, as agreed to by the agency
1146 and the hospital.
1147 (d) Contract with any federally qualified health center,
1148 if one exists within the agreed geopolitical boundaries,
1149 concerning the provision of primary care services, in order to
1150 guarantee delivery of services in a nonduplicative fashion, and
1151 to provide for referral arrangements, privileges, and
1152 admissions, as appropriate. The hospital shall agree to provide
1153 at an onsite or offsite facility primary care services within 24
1154 hours to which all Medicaid recipients and persons eligible
1155 under this paragraph who do not require emergency room services
1156 are referred during normal daylight hours.
1157 (e) Cooperate with the agency, the county, and other
1158 entities to ensure the provision of certain public health
1159 services, case management, referral and acceptance of patients,
1160 and sharing of epidemiological data, as the agency and the

1161 hospital find mutually necessary and desirable to promote and
1162 protect the public health within the agreed geopolitical
1163 boundaries.
1164 (f) In cooperation with the county in which the hospital
1165 resides, develop a low-cost, outpatient, prepaid health care
1166 program to persons who are not eligible for the Medicaid
1167 program, and who reside within the area.
1168 (g) Provide inpatient services to residents within the
1169 area who are not eligible for Medicaid or Medicare, and who do
1170 not have private health insurance, regardless of ability to pay,
1171 on the basis of available space, except that nothing shall
1172 prevent the hospital from establishing bill collection programs
1173 based on ability to pay.
1174 (h) Work with the Florida Healthy Kids Corporation, the
1175 Florida Health Care Purchasing Cooperative, and business health
1176 coalitions, as appropriate, to develop a feasibility study and
1177 plan to provide a low-cost comprehensive health insurance plan
1178 to persons who reside within the area and who do not have access
1179 to such a plan.
1180 (i) Work with public health officials and other experts to
1181 provide community health education and prevention activities
1182 designed to promote healthy lifestyles and appropriate use of
1183 health services.
1184 (j) Work with the local health council to develop a plan
1185 for promoting access to affordable health care services for all
1186 persons who reside within the area, including, but not limited
1187 to, public health services, primary care services, inpatient
1188 services, and affordable health insurance generally.
1189

1190 Any hospital that fails to comply with any of the provisions of
1191 this subsection, or any other contractual condition, may not
1192 receive payments under this section until full compliance is
1193 achieved.

1194 Section 17. Section 409.912, Florida Statutes, is amended
1195 to read:

1196 409.912 Cost-effective purchasing of health care.--The
1197 agency shall purchase goods and services for Medicaid recipients
1198 in the most cost-effective manner consistent with the delivery
1199 of quality medical care. The agency shall maximize the use of
1200 prepaid per capita and prepaid aggregate fixed-sum basis
1201 services when appropriate and other alternative service delivery
1202 and reimbursement methodologies, including competitive bidding
1203 pursuant to s. 287.057, designed to facilitate the cost-
1204 effective purchase of a case-managed continuum of care. The
1205 agency shall also require providers to minimize the exposure of
1206 recipients to the need for acute inpatient, custodial, and other
1207 institutional care and the inappropriate or unnecessary use of
1208 high-cost services. The agency may establish prior authorization
1209 requirements for certain populations of Medicaid beneficiaries,
1210 certain drug classes, or particular drugs to prevent fraud,
1211 abuse, overuse, and possible dangerous drug interactions. The
1212 Pharmaceutical and Therapeutics Committee shall make
1213 recommendations to the agency on drugs for which prior
1214 authorization is required. The agency shall inform the
1215 Pharmaceutical and Therapeutics Committee of its decisions
1216 regarding drugs subject to prior authorization. The agency is
1217 authorized to limit the entities it contracts with or enrolls as
1218 Medicaid providers by developing a provider network through

1219 provider credentialing. The agency may limit its network based
1220 on the assessment of beneficiary access to care, provider
1221 availability, provider quality standards, time and distance
1222 standards for access to care, the cultural competence of the
1223 provider network, demographic characteristics of Medicaid
1224 beneficiaries, practice and provider-to-beneficiary standards,
1225 appointment wait times, beneficiary use of services, provider
1226 turnover, provider profiling, provider licensure history,
1227 previous program integrity investigations and findings, peer
1228 review, provider Medicaid policy and billing compliance record,
1229 clinical and medical record audits, and other factors. Providers
1230 shall not be entitled to enrollment in the Medicaid provider
1231 network. The agency is authorized to seek federal waivers
1232 necessary to implement this policy.
1233 (1) The agency shall work with the Department of Children
1234 and Family Services to ensure access of children and families in
1235 the child protection system to needed and appropriate mental
1236 health and substance abuse services.
1237 (2) The agency may enter into agreements with appropriate
1238 agents of other state agencies or of any agency of the Federal
1239 Government and accept such duties in respect to social welfare
1240 or public aid as may be necessary to implement the provisions of
1241 Title XIX of the Social Security Act and ss. 409.901-409.920.
1242 (3) The agency may contract with health maintenance
1243 organizations certified pursuant to part I of chapter 641 for
1244 the provision of services to recipients.
1245 (4) The agency may contract with:
1246 (a) An entity that provides no prepaid health care
1247 services other than Medicaid services under contract with the

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1248 agency and which is owned and operated by a county, county
1249 health department, or county-owned and operated hospital to
1250 provide health care services on a prepaid or fixed-sum basis to
1251 recipients, which entity may provide such prepaid services
1252 either directly or through arrangements with other providers.
1253 Such prepaid health care services entities must be licensed
1254 under parts I and III by January 1, 1998, and until then are
1255 exempt from the provisions of part I of chapter 641. An entity
1256 recognized under this paragraph which demonstrates to the
1257 satisfaction of the Office of Insurance Regulation of the
1258 Financial Services Commission that it is backed by the full
1259 faith and credit of the county in which it is located may be
1260 exempted from s. 641.225.

1261 (b) An entity that is providing comprehensive behavioral
1262 health care services to certain Medicaid recipients through a
1263 capitated, prepaid arrangement pursuant to the federal waiver
1264 provided for by s. 409.905(5). Such an entity must be licensed
1265 under chapter 624, chapter 636, or chapter 641 and must possess
1266 the clinical systems and operational competence to manage risk
1267 and provide comprehensive behavioral health care to Medicaid
1268 recipients. As used in this paragraph, the term "comprehensive
1269 behavioral health care services" means covered mental health and
1270 substance abuse treatment services that are available to
1271 Medicaid recipients. The secretary of the Department of Children
1272 and Family Services shall approve provisions of procurements
1273 related to children in the department's care or custody prior to
1274 enrolling such children in a prepaid behavioral health plan. Any
1275 contract awarded under this paragraph must be competitively
1276 procured. In developing the behavioral health care prepaid plan

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1277 procurement document, the agency shall ensure that the
1278 procurement document requires the contractor to develop and
1279 implement a plan to ensure compliance with s. 394.4574 related
1280 to services provided to residents of licensed assisted living
1281 facilities that hold a limited mental health license. Except as
1282 provided in subparagraph 8., the agency shall seek federal
1283 approval to contract with a single entity meeting these
1284 requirements to provide comprehensive behavioral health care
1285 services to all Medicaid recipients not enrolled in a managed
1286 care plan in an AHCA area. Each entity must offer sufficient
1287 choice of providers in its network to ensure recipient access to
1288 care and the opportunity to select a provider with whom they are
1289 satisfied. The network shall include all public mental health
1290 hospitals. To ensure unimpaired access to behavioral health care
1291 services by Medicaid recipients, all contracts issued pursuant
1292 to this paragraph shall require 80 percent of the capitation
1293 paid to the managed care plan, including health maintenance
1294 organizations, to be expended for the provision of behavioral
1295 health care services. In the event the managed care plan expends
1296 less than 80 percent of the capitation paid pursuant to this
1297 paragraph for the provision of behavioral health care services,
1298 the difference shall be returned to the agency. The agency shall
1299 provide the managed care plan with a certification letter
1300 indicating the amount of capitation paid during each calendar
1301 year for the provision of behavioral health care services
1302 pursuant to this section. The agency may reimburse for substance
1303 abuse treatment services on a fee-for-service basis until the
1304 agency finds that adequate funds are available for capitated,
1305 prepaid arrangements.

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1306 1. By January 1, 2001, the agency shall modify the
1307 contracts with the entities providing comprehensive inpatient
1308 and outpatient mental health care services to Medicaid
1309 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
1310 Counties, to include substance abuse treatment services.
1311 2. By July 1, 2003, the agency and the Department of
1312 Children and Family Services shall execute a written agreement
1313 that requires collaboration and joint development of all policy,
1314 budgets, procurement documents, contracts, and monitoring plans
1315 that have an impact on the state and Medicaid community mental
1316 health and targeted case management programs.
1317 3. Except as provided in subparagraph 8., by July 1, 2006,
1318 the agency and the Department of Children and Family Services
1319 shall contract with managed care entities in each AHCA area
1320 except area 6 or arrange to provide comprehensive inpatient and
1321 outpatient mental health and substance abuse services through
1322 capitated prepaid arrangements to all Medicaid recipients who
1323 are eligible to participate in such plans under federal law and
1324 regulation. In AHCA areas where eligible individuals number less
1325 than 150,000, the agency shall contract with a single managed
1326 care plan to provide comprehensive behavioral health services to
1327 all recipients who are not enrolled in a Medicaid health
1328 maintenance organization. The agency may contract with more than
1329 one comprehensive behavioral health provider to provide care to
1330 recipients who are not enrolled in a Medicaid health maintenance
1331 organization ~~plan~~ in AHCA areas where the eligible population
1332 exceeds 150,000. Contracts for comprehensive behavioral health
1333 providers awarded pursuant to this section shall be
1334 competitively procured. Both for-profit and not-for-profit

1335 corporations shall be eligible to compete. Managed care plans
1336 contracting with the agency under subsection (3) shall provide
1337 and receive payment for the same comprehensive behavioral health
1338 benefits as provided in AHCA rules, including handbooks
1339 incorporated by reference.
1340 4. By October 1, 2003, the agency and the department shall
1341 submit a plan to the Governor, the President of the Senate, and
1342 the Speaker of the House of Representatives which provides for
1343 the full implementation of capitated prepaid behavioral health
1344 care in all areas of the state. ~~The plan shall include~~
1345 ~~provisions which ensure that children and families receiving~~
1346 ~~foster care and other related services are appropriately served~~
1347 ~~and that these services assist the community-based care lead~~
1348 ~~agencies in meeting the goals and outcomes of the child welfare~~
1349 ~~system. The plan will be developed with the participation of~~
1350 ~~community-based lead agencies, community alliances, sheriffs,~~
1351 ~~and community providers serving dependent children.~~
1352 a. Implementation shall begin in 2003 in those AHCA areas
1353 of the state where the agency is able to establish sufficient
1354 capitation rates.
1355 b. If the agency determines that the proposed capitation
1356 rate in any area is insufficient to provide appropriate
1357 services, the agency may adjust the capitation rate to ensure
1358 that care will be available. The agency and the department may
1359 use existing general revenue to address any additional required
1360 match but may not over-obligate existing funds on an annualized
1361 basis.
1362 c. Subject to any limitations provided for in the General
1363 Appropriations Act, the agency, in compliance with appropriate

1364 federal authorization, shall develop policies and procedures
1365 that allow for certification of local and state funds.
1366 5. Children residing in a statewide inpatient psychiatric
1367 program, or in a Department of Juvenile Justice or a Department
1368 of Children and Family Services residential program approved as
1369 a Medicaid behavioral health overlay services provider shall not
1370 be included in a behavioral health care prepaid health plan or
1371 any other Medicaid managed care plan pursuant to this paragraph.
1372 6. In converting to a prepaid system of delivery, the
1373 agency shall in its procurement document require an entity
1374 providing only comprehensive behavioral health care services to
1375 prevent the displacement of indigent care patients by enrollees
1376 in the Medicaid prepaid health plan providing behavioral health
1377 care services from facilities receiving state funding to provide
1378 indigent behavioral health care, to facilities licensed under
1379 chapter 395 which do not receive state funding for indigent
1380 behavioral health care, or reimburse the unsubsidized facility
1381 for the cost of behavioral health care provided to the displaced
1382 indigent care patient.
1383 7. Traditional community mental health providers under
1384 contract with the Department of Children and Family Services
1385 pursuant to part IV of chapter 394, child welfare providers
1386 under contract with the Department of Children and Family
1387 Services in areas 1 and 6, and inpatient mental health providers
1388 licensed pursuant to chapter 395 must be offered an opportunity
1389 to accept or decline a contract to participate in any provider
1390 network for prepaid behavioral health services.
1391 8. For fiscal year 2004-2005, all Medicaid eligible
1392 children, except children in areas 1 and 6, whose cases are open

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1393 for child welfare services in the HomeSafeNet system, shall be
1394 enrolled in MediPass or in Medicaid fee-for-service and all
1395 their behavioral health care services including inpatient,
1396 outpatient psychiatric, community mental health, and case
1397 management shall be reimbursed on a fee-for-service basis.
1398 Beginning July 1, 2005, such children, who are open for child
1399 welfare services in the HomeSafeNet system, shall receive their
1400 behavioral health care services through a specialty prepaid plan
1401 operated by community-based lead agencies either through a
1402 single agency or formal agreements among several agencies. The
1403 specialty prepaid plan must result in savings to the state
1404 comparable to savings achieved in other Medicaid managed care
1405 and prepaid programs. Such plan must provide mechanisms to
1406 maximize state and local revenues. The specialty prepaid plan
1407 shall be developed by the agency and The Department of Children
1408 and Family Services. The agency is authorized to seek any
1409 federal waivers to implement this initiative.
1410 (c) A federally qualified health center or an entity owned
1411 by one or more federally qualified health centers or an entity
1412 owned by other migrant and community health centers receiving
1413 non-Medicaid financial support from the Federal Government to
1414 provide health care services on a prepaid or fixed-sum basis to
1415 recipients. Such prepaid health care services entity must be
1416 licensed under parts I and III of chapter 641, but shall be
1417 prohibited from serving Medicaid recipients on a prepaid basis,
1418 until such licensure has been obtained. However, such an entity
1419 is exempt from s. 641.225 if the entity meets the requirements
1420 specified in subsections (17) ~~(15)~~ and (18) ~~(16)~~.
1421 (d) A provider service network may be reimbursed on a fee-

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1422 for-service or prepaid basis. A provider service network which
1423 is reimbursed by the agency on a prepaid basis shall be exempt
1424 from parts I and III of chapter 641, but must meet appropriate
1425 financial reserve, quality assurance, and patient rights
1426 requirements as established by the agency. The agency shall
1427 award contracts on a competitive bid basis and shall select
1428 bidders based upon price and quality of care. Medicaid
1429 recipients assigned to a demonstration project shall be chosen
1430 equally from those who would otherwise have been assigned to
1431 prepaid plans and MediPass. The agency is authorized to seek
1432 federal Medicaid waivers as necessary to implement the
1433 provisions of this section.
1434 (e) An entity that provides only comprehensive behavioral
1435 health care services to certain Medicaid recipients through an
1436 administrative services organization agreement. Such an entity
1437 must possess the clinical systems and operational competence to
1438 provide comprehensive health care to Medicaid recipients. As
1439 used in this paragraph, the term "comprehensive behavioral
1440 health care services" means covered mental health and substance
1441 abuse treatment services that are available to Medicaid
1442 recipients. Any contract awarded under this paragraph must be
1443 competitively procured. The agency must ensure that Medicaid
1444 recipients have available the choice of at least two managed
1445 care plans for their behavioral health care services.
1446 (f) An entity that provides in-home physician services to
1447 test the cost-effectiveness of enhanced home-based medical care
1448 to Medicaid recipients with degenerative neurological diseases
1449 and other diseases or disabling conditions associated with high
1450 costs to Medicaid. The program shall be designed to serve very

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1451 disabled persons and to reduce Medicaid reimbursed costs for
1452 inpatient, outpatient, and emergency department services. The
1453 agency shall contract with vendors on a risk-sharing basis.
1454 (g) Children's provider networks that provide care
1455 coordination and care management for Medicaid-eligible pediatric
1456 patients, primary care, authorization of specialty care, and
1457 other urgent and emergency care through organized providers
1458 designed to service Medicaid eligibles under age 18 and
1459 pediatric emergency departments' diversion programs. The
1460 networks shall provide after-hour operations, including evening
1461 and weekend hours, to promote, when appropriate, the use of the
1462 children's networks rather than hospital emergency departments.
1463 (h) An entity authorized in s. 430.205 to contract with
1464 the agency and the Department of Elderly Affairs to provide
1465 health care and social services on a prepaid or fixed-sum basis
1466 to elderly recipients. Such prepaid health care services
1467 entities are exempt from the provisions of part I of chapter 641
1468 for the first 3 years of operation. An entity recognized under
1469 this paragraph that demonstrates to the satisfaction of the
1470 Office of Insurance Regulation that it is backed by the full
1471 faith and credit of one or more counties in which it operates
1472 may be exempted from s. 641.225.
1473 (i) A Children's Medical Services network, as defined in
1474 s. 391.021.
1475 (5) By October 1, 2003, the agency and the department
1476 shall, to the extent feasible, develop a plan for implementing
1477 new Medicaid procedure codes for emergency and crisis care,
1478 supportive residential services, and other services designed to
1479 maximize the use of Medicaid funds for Medicaid-eligible

1480 recipients. The agency shall include in the agreement developed
1481 pursuant to subsection (4) a provision that ensures that the
1482 match requirements for these new procedure codes are met by
1483 certifying eligible general revenue or local funds that are
1484 currently expended on these services by the department with
1485 contracted alcohol, drug abuse, and mental health providers. The
1486 plan must describe specific procedure codes to be implemented, a
1487 projection of the number of procedures to be delivered during
1488 fiscal year 2003-2004, and a financial analysis that describes
1489 the certified match procedures, and accountability mechanisms,
1490 projects the earnings associated with these procedures, and
1491 describes the sources of state match. This plan may not be
1492 implemented in any part until approved by the Legislative Budget
1493 Commission. If such approval has not occurred by December 31,
1494 2003, the plan shall be submitted for consideration by the 2004
1495 Legislature.
1496 (6) The agency may contract with any public or private
1497 entity otherwise authorized by this section on a prepaid or
1498 fixed-sum basis for the provision of health care services to
1499 recipients. An entity may provide prepaid services to
1500 recipients, either directly or through arrangements with other
1501 entities, if each entity involved in providing services:
1502 (a) Is organized primarily for the purpose of providing
1503 health care or other services of the type regularly offered to
1504 Medicaid recipients;
1505 (b) Ensures that services meet the standards set by the
1506 agency for quality, appropriateness, and timeliness;
1507 (c) Makes provisions satisfactory to the agency for
1508 insolvency protection and ensures that neither enrolled Medicaid

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1509 recipients nor the agency will be liable for the debts of the
1510 entity;
1511 (d) Submits to the agency, if a private entity, a
1512 financial plan that the agency finds to be fiscally sound and
1513 that provides for working capital in the form of cash or
1514 equivalent liquid assets excluding revenues from Medicaid
1515 premium payments equal to at least the first 3 months of
1516 operating expenses or $200,000, whichever is greater;
1517 (e) Furnishes evidence satisfactory to the agency of
1518 adequate liability insurance coverage or an adequate plan of
1519 self-insurance to respond to claims for injuries arising out of
1520 the furnishing of health care;
1521 (f) Provides, through contract or otherwise, for periodic
1522 review of its medical facilities and services, as required by
1523 the agency; and
1524 (g) Provides organizational, operational, financial, and
1525 other information required by the agency.
1526 (7) The agency may contract on a prepaid or fixed-sum
1527 basis with any health insurer that:
1528 (a) Pays for health care services provided to enrolled
1529 Medicaid recipients in exchange for a premium payment paid by
1530 the agency;
1531 (b) Assumes the underwriting risk; and
1532 (c) Is organized and licensed under applicable provisions
1533 of the Florida Insurance Code and is currently in good standing
1534 with the Office of Insurance Regulation.
1535 (8) The agency may contract on a prepaid or fixed-sum
1536 basis with an exclusive provider organization to provide health
1537 care services to Medicaid recipients provided that the exclusive

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1538 provider organization meets applicable managed care plan
1539 requirements in this section, ss. 409.9122, 409.9123, 409.9128,
1540 and 627.6472, and other applicable provisions of law.
1541 (9) The Agency for Health Care Administration may provide
1542 cost-effective purchasing of chiropractic services on a fee-for-
1543 service basis to Medicaid recipients through arrangements with a
1544 statewide chiropractic preferred provider organization
1545 incorporated in this state as a not-for-profit corporation. The
1546 agency shall ensure that the benefit limits and prior
1547 authorization requirements in the current Medicaid program shall
1548 apply to the services provided by the chiropractic preferred
1549 provider organization.
1550 (10) The agency shall not contract on a prepaid or fixed-
1551 sum basis for Medicaid services with an entity which knows or
1552 reasonably should know that any officer, director, agent,
1553 managing employee, or owner of stock or beneficial interest in
1554 excess of 5 percent common or preferred stock, or the entity
1555 itself, has been found guilty of, regardless of adjudication, or
1556 entered a plea of nolo contendere, or guilty, to:
1557 (a) Fraud;
1558 (b) Violation of federal or state antitrust statutes,
1559 including those proscribing price fixing between competitors and
1560 the allocation of customers among competitors;
1561 (c) Commission of a felony involving embezzlement, theft,
1562 forgery, income tax evasion, bribery, falsification or
1563 destruction of records, making false statements, receiving
1564 stolen property, making false claims, or obstruction of justice;
1565 or
1566 (d) Any crime in any jurisdiction which directly relates

1567 to the provision of health services on a prepaid or fixed-sum
1568 basis.
1569 (11) The agency, after notifying the Legislature, may
1570 apply for waivers of applicable federal laws and regulations as
1571 necessary to implement more appropriate systems of health care
1572 for Medicaid recipients and reduce the cost of the Medicaid
1573 program to the state and federal governments and shall implement
1574 such programs, after legislative approval, within a reasonable
1575 period of time after federal approval. These programs must be
1576 designed primarily to reduce the need for inpatient care,
1577 custodial care and other long-term or institutional care, and
1578 other high-cost services.
1579 (a) Prior to seeking legislative approval of such a waiver
1580 as authorized by this subsection, the agency shall provide
1581 notice and an opportunity for public comment. Notice shall be
1582 provided to all persons who have made requests of the agency for
1583 advance notice and shall be published in the Florida
1584 Administrative Weekly not less than 28 days prior to the
1585 intended action.
1586 (b) Notwithstanding s. 216.292, funds that are
1587 appropriated to the Department of Elderly Affairs for the
1588 Assisted Living for the Elderly Medicaid waiver and are not
1589 expended shall be transferred to the agency to fund Medicaid-
1590 reimbursed nursing home care.
1591 (12) The agency shall establish a postpayment utilization
1592 control program designed to identify recipients who may
1593 inappropriately overuse or underuse Medicaid services and shall
1594 provide methods to correct such misuse.
1595 (13) The agency shall develop and provide coordinated

1596 systems of care for Medicaid recipients and may contract with
1597 public or private entities to develop and administer such
1598 systems of care among public and private health care providers
1599 in a given geographic area.
1600 (14) The agency shall operate or contract for the
1601 operation of utilization management and incentive systems
1602 designed to encourage cost-effective use services.
1603 (15)(a) The agency shall operate the Comprehensive
1604 Assessment and Review (CARES) nursing facility preadmission
1605 screening program to ensure that Medicaid payment for nursing
1606 facility care is made only for individuals whose conditions
1607 require such care and to ensure that long-term care services are
1608 provided in the setting most appropriate to the needs of the
1609 person and in the most economical manner possible. The CARES
1610 program shall also ensure that individuals participating in
1611 Medicaid home and community-based waiver programs meet criteria
1612 for those programs, consistent with approved federal waivers.
1613 (b) The agency shall operate the CARES program through an
1614 interagency agreement with the Department of Elderly Affairs.
1615 (c) Prior to making payment for nursing facility services
1616 for a Medicaid recipient, the agency must verify that the
1617 nursing facility preadmission screening program has determined
1618 that the individual requires nursing facility care and that the
1619 individual cannot be safely served in community-based programs.
1620 The nursing facility preadmission screening program shall refer
1621 a Medicaid recipient to a community-based program if the
1622 individual could be safely served at a lower cost and the
1623 recipient chooses to participate in such program.
1624 (d) By January 1 of each year, the agency shall submit a

1625 report to the Legislature and the Office of Long-Term-Care
1626 Policy describing the operations of the CARES program. The
1627 report must describe:
1628 1. Rate of diversion to community alternative programs;
1629 2. CARES program staffing needs to achieve additional
1630 diversions;
1631 3. Reasons the program is unable to place individuals in
1632 less restrictive settings when such individuals desired such
1633 services and could have been served in such settings;
1634 4. Barriers to appropriate placement, including barriers
1635 due to policies or operations of other agencies or state-funded
1636 programs; and
1637 5. Statutory changes necessary to ensure that individuals
1638 in need of long-term care services receive care in the least
1639 restrictive environment.
1640 (16)(a) The agency shall identify health care utilization
1641 and price patterns within the Medicaid program which are not
1642 cost-effective or medically appropriate and assess the
1643 effectiveness of new or alternate methods of providing and
1644 monitoring service, and may implement such methods as it
1645 considers appropriate. Such methods may include disease
1646 management initiatives, an integrated and systematic approach
1647 for managing the health care needs of recipients who are at risk
1648 of or diagnosed with a specific disease by using best practices,
1649 prevention strategies, clinical-practice improvement, clinical
1650 interventions and protocols, outcomes research, information
1651 technology, and other tools and resources to reduce overall
1652 costs and improve measurable outcomes.
1653 (b) The responsibility of the agency under this subsection

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1654 shall include the development of capabilities to identify actual
1655 and optimal practice patterns; patient and provider educational
1656 initiatives; methods for determining patient compliance with
1657 prescribed treatments; fraud, waste, and abuse prevention and
1658 detection programs; and beneficiary case management programs.
1659 1. The practice pattern identification program shall
1660 evaluate practitioner prescribing patterns based on national and
1661 regional practice guidelines, comparing practitioners to their
1662 peer groups. The agency and its Drug Utilization Review Board
1663 shall consult with a panel of practicing health care
1664 professionals consisting of the following: the Speaker of the
1665 House of Representatives and the President of the Senate shall
1666 each appoint three physicians licensed under chapter 458 or
1667 chapter 459; and the Governor shall appoint two pharmacists
1668 licensed under chapter 465 and one dentist licensed under
1669 chapter 466 who is an oral surgeon. Terms of the panel members
1670 shall expire at the discretion of the appointing official. The
1671 panel shall begin its work by August 1, 1999, regardless of the
1672 number of appointments made by that date. The advisory panel
1673 shall be responsible for evaluating treatment guidelines and
1674 recommending ways to incorporate their use in the practice
1675 pattern identification program. Practitioners who are
1676 prescribing inappropriately or inefficiently, as determined by
1677 the agency, may have their prescribing of certain drugs subject
1678 to prior authorization.
1679 2. The agency shall also develop educational interventions
1680 designed to promote the proper use of medications by providers
1681 and beneficiaries.
1682 3. The agency shall implement a pharmacy fraud, waste, and

1683 abuse initiative that may include a surety bond or letter of
1684 credit requirement for participating pharmacies, enhanced
1685 provider auditing practices, the use of additional fraud and
1686 abuse software, recipient management programs for beneficiaries
1687 inappropriately using their benefits, and other steps that will
1688 eliminate provider and recipient fraud, waste, and abuse. The
1689 initiative shall address enforcement efforts to reduce the
1690 number and use of counterfeit prescriptions.
1691 4. By September 30, 2002, the agency shall contract with
1692 an entity in the state to implement a wireless handheld clinical
1693 pharmacology drug information database for practitioners. The
1694 initiative shall be designed to enhance the agency's efforts to
1695 reduce fraud, abuse, and errors in the prescription drug benefit
1696 program and to otherwise further the intent of this paragraph.
1697 5. The agency may apply for any federal waivers needed to
1698 implement this paragraph.
1699 (17) An entity contracting on a prepaid or fixed-sum basis
1700 shall, in addition to meeting any applicable statutory surplus
1701 requirements, also maintain at all times in the form of cash,
1702 investments that mature in less than 180 days allowable as
1703 admitted assets by the Office of Insurance Regulation, and
1704 restricted funds or deposits controlled by the agency or the
1705 Office of Insurance Regulation, a surplus amount equal to one-
1706 and-one-half times the entity's monthly Medicaid prepaid
1707 revenues. As used in this subsection, the term "surplus" means
1708 the entity's total assets minus total liabilities. If an
1709 entity's surplus falls below an amount equal to one-and-one-half
1710 times the entity's monthly Medicaid prepaid revenues, the agency
1711 shall prohibit the entity from engaging in marketing and

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1712 preenrollment activities, shall cease to process new
1713 enrollments, and shall not renew the entity's contract until the
1714 required balance is achieved. The requirements of this
1715 subsection do not apply:
1716 (a) Where a public entity agrees to fund any deficit
1717 incurred by the contracting entity; or
1718 (b) Where the entity's performance and obligations are
1719 guaranteed in writing by a guaranteeing organization which:
1720 1. Has been in operation for at least 5 years and has
1721 assets in excess of $50 million; or
1722 2. Submits a written guarantee acceptable to the agency
1723 which is irrevocable during the term of the contracting entity's
1724 contract with the agency and, upon termination of the contract,
1725 until the agency receives proof of satisfaction of all
1726 outstanding obligations incurred under the contract.
1727 (18)(a) The agency may require an entity contracting on a
1728 prepaid or fixed-sum basis to establish a restricted insolvency
1729 protection account with a federally guaranteed financial
1730 institution licensed to do business in this state. The entity
1731 shall deposit into that account 5 percent of the capitation
1732 payments made by the agency each month until a maximum total of
1733 2 percent of the total current contract amount is reached. The
1734 restricted insolvency protection account may be drawn upon with
1735 the authorized signatures of two persons designated by the
1736 entity and two representatives of the agency. If the agency
1737 finds that the entity is insolvent, the agency may draw upon the
1738 account solely with the two authorized signatures of
1739 representatives of the agency, and the funds may be disbursed to
1740 meet financial obligations incurred by the entity under the

1741 prepaid contract. If the contract is terminated, expired, or not
1742 continued, the account balance must be released by the agency to
1743 the entity upon receipt of proof of satisfaction of all
1744 outstanding obligations incurred under this contract.
1745 (b) The agency may waive the insolvency protection account
1746 requirement in writing when evidence is on file with the agency
1747 of adequate insolvency insurance and reinsurance that will
1748 protect enrollees if the entity becomes unable to meet its
1749 obligations.
1750 (19) An entity that contracts with the agency on a prepaid
1751 or fixed-sum basis for the provision of Medicaid services shall
1752 reimburse any hospital or physician that is outside the entity's
1753 authorized geographic service area as specified in its contract
1754 with the agency, and that provides services authorized by the
1755 entity to its members, at a rate negotiated with the hospital or
1756 physician for the provision of services or according to the
1757 lesser of the following:
1758 (a) The usual and customary charges made to the general
1759 public by the hospital or physician; or
1760 (b) The Florida Medicaid reimbursement rate established
1761 for the hospital or physician.
1762 (20) When a merger or acquisition of a Medicaid prepaid
1763 contractor has been approved by the Office of Insurance
1764 Regulation pursuant to s. 628.4615, the agency shall approve the
1765 assignment or transfer of the appropriate Medicaid prepaid
1766 contract upon request of the surviving entity of the merger or
1767 acquisition if the contractor and the other entity have been in
1768 good standing with the agency for the most recent 12-month
1769 period, unless the agency determines that the assignment or

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1770 transfer would be detrimental to the Medicaid recipients or the
1771 Medicaid program. To be in good standing, an entity must not
1772 have failed accreditation or committed any material violation of
1773 the requirements of s. 641.52 and must meet the Medicaid
1774 contract requirements. For purposes of this section, a merger or
1775 acquisition means a change in controlling interest of an entity,
1776 including an asset or stock purchase.
1777 (21) Any entity contracting with the agency pursuant to
1778 this section to provide health care services to Medicaid
1779 recipients is prohibited from engaging in any of the following
1780 practices or activities:
1781 (a) Practices that are discriminatory, including, but not
1782 limited to, attempts to discourage participation on the basis of
1783 actual or perceived health status.
1784 (b) Activities that could mislead or confuse recipients,
1785 or misrepresent the organization, its marketing representatives,
1786 or the agency. Violations of this paragraph include, but are not
1787 limited to:
1788 1. False or misleading claims that marketing
1789 representatives are employees or representatives of the state or
1790 county, or of anyone other than the entity or the organization
1791 by whom they are reimbursed.
1792 2. False or misleading claims that the entity is
1793 recommended or endorsed by any state or county agency, or by any
1794 other organization which has not certified its endorsement in
1795 writing to the entity.
1796 3. False or misleading claims that the state or county
1797 recommends that a Medicaid recipient enroll with an entity.
1798 4. Claims that a Medicaid recipient will lose benefits

1799 under the Medicaid program, or any other health or welfare
1800 benefits to which the recipient is legally entitled, if the
1801 recipient does not enroll with the entity.
1802 (c) Granting or offering of any monetary or other valuable
1803 consideration for enrollment, except as authorized by subsection
1804 (24) ~~(22)~~.
1805 (d) Door-to-door solicitation of recipients who have not
1806 contacted the entity or who have not invited the entity to make
1807 a presentation.
1808 (e) Solicitation of Medicaid recipients by marketing
1809 representatives stationed in state offices unless approved and
1810 supervised by the agency or its agent and approved by the
1811 affected state agency when solicitation occurs in an office of
1812 the state agency. The agency shall ensure that marketing
1813 representatives stationed in state offices shall market their
1814 managed care plans to Medicaid recipients only in designated
1815 areas and in such a way as to not interfere with the recipients'
1816 activities in the state office.
1817 (f) Enrollment of Medicaid recipients.
1818 (22) The agency may impose a fine for a violation of this
1819 section or the contract with the agency by a person or entity
1820 that is under contract with the agency. With respect to any
1821 nonwillful violation, such fine shall not exceed $2,500 per
1822 violation. In no event shall such fine exceed an aggregate
1823 amount of $10,000 for all nonwillful violations arising out of
1824 the same action. With respect to any knowing and willful
1825 violation of this section or the contract with the agency, the
1826 agency may impose a fine upon the entity in an amount not to
1827 exceed $20,000 for each such violation. In no event shall such

1828 fine exceed an aggregate amount of $100,000 for all knowing and
1829 willful violations arising out of the same action.
1830 (23) A health maintenance organization or a person or
1831 entity exempt from chapter 641 that is under contract with the
1832 agency for the provision of health care services to Medicaid
1833 recipients may not use or distribute marketing materials used to
1834 solicit Medicaid recipients, unless such materials have been
1835 approved by the agency. The provisions of this subsection do not
1836 apply to general advertising and marketing materials used by a
1837 health maintenance organization to solicit both non-Medicaid
1838 subscribers and Medicaid recipients.
1839 (24) Upon approval by the agency, health maintenance
1840 organizations and persons or entities exempt from chapter 641
1841 that are under contract with the agency for the provision of
1842 health care services to Medicaid recipients may be permitted
1843 within the capitation rate to provide additional health benefits
1844 that the agency has found are of high quality, are practicably
1845 available, provide reasonable value to the recipient, and are
1846 provided at no additional cost to the state.
1847 (25) The agency shall utilize the statewide health
1848 maintenance organization complaint hotline for the purpose of
1849 investigating and resolving Medicaid and prepaid health plan
1850 complaints, maintaining a record of complaints and confirmed
1851 problems, and receiving disenrollment requests made by
1852 recipients.
1853 (26) The agency shall require the publication of the
1854 health maintenance organization's and the prepaid health plan's
1855 consumer services telephone numbers and the "800" telephone
1856 number of the statewide health maintenance organization

1857 complaint hotline on each Medicaid identification card issued by
1858 a health maintenance organization or prepaid health plan
1859 contracting with the agency to serve Medicaid recipients and on
1860 each subscriber handbook issued to a Medicaid recipient.
1861 (27) The agency shall establish a health care quality
1862 improvement system for those entities contracting with the
1863 agency pursuant to this section, incorporating all the standards
1864 and guidelines developed by the Medicaid Bureau of the Health
1865 Care Financing Administration as a part of the quality assurance
1866 reform initiative. The system shall include, but need not be
1867 limited to, the following:
1868 (a) Guidelines for internal quality assurance programs,
1869 including standards for:
1870 1. Written quality assurance program descriptions.
1871 2. Responsibilities of the governing body for monitoring,
1872 evaluating, and making improvements to care.
1873 3. An active quality assurance committee.
1874 4. Quality assurance program supervision.
1875 5. Requiring the program to have adequate resources to
1876 effectively carry out its specified activities.
1877 6. Provider participation in the quality assurance
1878 program.
1879 7. Delegation of quality assurance program activities.
1880 8. Credentialing and recredentialing.
1881 9. Enrollee rights and responsibilities.
1882 10. Availability and accessibility to services and care.
1883 11. Ambulatory care facilities.
1884 12. Accessibility and availability of medical records, as
1885 well as proper recordkeeping and process for record review.

1886 13. Utilization review.
1887 14. A continuity of care system.
1888 15. Quality assurance program documentation.
1889 16. Coordination of quality assurance activity with other
1890 management activity.
1891 17. Delivering care to pregnant women and infants; to
1892 elderly and disabled recipients, especially those who are at
1893 risk of institutional placement; to persons with developmental
1894 disabilities; and to adults who have chronic, high-cost medical
1895 conditions.
1896 (b) Guidelines which require the entities to conduct
1897 quality-of-care studies which:
1898 1. Target specific conditions and specific health service
1899 delivery issues for focused monitoring and evaluation.
1900 2. Use clinical care standards or practice guidelines to
1901 objectively evaluate the care the entity delivers or fails to
1902 deliver for the targeted clinical conditions and health services
1903 delivery issues.
1904 3. Use quality indicators derived from the clinical care
1905 standards or practice guidelines to screen and monitor care and
1906 services delivered.
1907 (c) Guidelines for external quality review of each
1908 contractor which require: focused studies of patterns of care;
1909 individual care review in specific situations; and followup
1910 activities on previous pattern-of-care study findings and
1911 individual-care-review findings. In designing the external
1912 quality review function and determining how it is to operate as
1913 part of the state's overall quality improvement system, the
1914 agency shall construct its external quality review organization

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1915 and entity contracts to address each of the following:
1916 1. Delineating the role of the external quality review
1917 organization.
1918 2. Length of the external quality review organization
1919 contract with the state.
1920 3. Participation of the contracting entities in designing
1921 external quality review organization review activities.
1922 4. Potential variation in the type of clinical conditions
1923 and health services delivery issues to be studied at each plan.
1924 5. Determining the number of focused pattern-of-care
1925 studies to be conducted for each plan.
1926 6. Methods for implementing focused studies.
1927 7. Individual care review.
1928 8. Followup activities.
1929 (28) In order to ensure that children receive health care
1930 services for which an entity has already been compensated, an
1931 entity contracting with the agency pursuant to this section
1932 shall achieve an annual Early and Periodic Screening, Diagnosis,
1933 and Treatment (EPSDT) Service screening rate of at least 60
1934 percent for those recipients continuously enrolled for at least
1935 8 months. The agency shall develop a method by which the EPSDT
1936 screening rate shall be calculated. For any entity which does
1937 not achieve the annual 60 percent rate, the entity must submit a
1938 corrective action plan for the agency's approval. If the entity
1939 does not meet the standard established in the corrective action
1940 plan during the specified timeframe, the agency is authorized to
1941 impose appropriate contract sanctions. At least annually, the
1942 agency shall publicly release the EPSDT Services screening rates
1943 of each entity it has contracted with on a prepaid basis to

1944 serve Medicaid recipients.
1945 (29) The agency shall perform enrollments and
1946 disenrollments for Medicaid recipients who are eligible for
1947 MediPass or managed care plans. Notwithstanding the prohibition
1948 contained in paragraph (21)~~(19)~~(f), managed care plans may
1949 perform preenrollments of Medicaid recipients under the
1950 supervision of the agency or its agents. For the purposes of
1951 this section, "preenrollment" means the provision of marketing
1952 and educational materials to a Medicaid recipient and assistance
1953 in completing the application forms, but shall not include
1954 actual enrollment into a managed care plan. An application for
1955 enrollment shall not be deemed complete until the agency or its
1956 agent verifies that the recipient made an informed, voluntary
1957 choice. The agency, in cooperation with the Department of
1958 Children and Family Services, may test new marketing initiatives
1959 to inform Medicaid recipients about their managed care options
1960 at selected sites. The agency shall report to the Legislature on
1961 the effectiveness of such initiatives. The agency may contract
1962 with a third party to perform managed care plan and MediPass
1963 enrollment and disenrollment services for Medicaid recipients
1964 and is authorized to adopt rules to implement such services. The
1965 agency may adjust the capitation rate only to cover the costs of
1966 a third-party enrollment and disenrollment contract, and for
1967 agency supervision and management of the managed care plan
1968 enrollment and disenrollment contract.
1969 (30) Any lists of providers made available to Medicaid
1970 recipients, MediPass enrollees, or managed care plan enrollees
1971 shall be arranged alphabetically showing the provider's name and
1972 specialty and, separately, by specialty in alphabetical order.

1973 (31) The agency shall establish an enhanced managed care
1974 quality assurance oversight function, to include at least the
1975 following components:
1976 (a) At least quarterly analysis and followup, including
1977 sanctions as appropriate, of managed care participant
1978 utilization of services.
1979 (b) At least quarterly analysis and followup, including
1980 sanctions as appropriate, of quality findings of the Medicaid
1981 peer review organization and other external quality assurance
1982 programs.
1983 (c) At least quarterly analysis and followup, including
1984 sanctions as appropriate, of the fiscal viability of managed
1985 care plans.
1986 (d) At least quarterly analysis and followup, including
1987 sanctions as appropriate, of managed care participant
1988 satisfaction and disenrollment surveys.
1989 (e) The agency shall conduct regular and ongoing Medicaid
1990 recipient satisfaction surveys.
1991
1992 The analyses and followup activities conducted by the agency
1993 under its enhanced managed care quality assurance oversight
1994 function shall not duplicate the activities of accreditation
1995 reviewers for entities regulated under part III of chapter 641,
1996 but may include a review of the finding of such reviewers.
1997 (32) Each managed care plan that is under contract with
1998 the agency to provide health care services to Medicaid
1999 recipients shall annually conduct a background check with the
2000 Florida Department of Law Enforcement of all persons with
2001 ownership interest of 5 percent or more or executive management

2002 responsibility for the managed care plan and shall submit to the
2003 agency information concerning any such person who has been found
2004 guilty of, regardless of adjudication, or has entered a plea of
2005 nolo contendere or guilty to, any of the offenses listed in s.
2006 435.03.
2007 (33) The agency shall, by rule, develop a process whereby
2008 a Medicaid managed care plan enrollee who wishes to enter
2009 hospice care may be disenrolled from the managed care plan
2010 within 24 hours after contacting the agency regarding such
2011 request. The agency rule shall include a methodology for the
2012 agency to recoup managed care plan payments on a pro rata basis
2013 if payment has been made for the enrollment month when
2014 disenrollment occurs.
2015 (34) The agency and entities which contract with the
2016 agency to provide health care services to Medicaid recipients
2017 under this section or s. 409.9122 must comply with the
2018 provisions of s. 641.513 in providing emergency services and
2019 care to Medicaid recipients and MediPass recipients.
2020 (35) All entities providing health care services to
2021 Medicaid recipients shall make available, and encourage all
2022 pregnant women and mothers with infants to receive, and provide
2023 documentation in the medical records to reflect, the following:
2024 (a) Healthy Start prenatal or infant screening.
2025 (b) Healthy Start care coordination, when screening or
2026 other factors indicate need.
2027 (c) Healthy Start enhanced services in accordance with the
2028 prenatal or infant screening results.
2029 (d) Immunizations in accordance with recommendations of
2030 the Advisory Committee on Immunization Practices of the United

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2031 States Public Health Service and the American Academy of
2032 Pediatrics, as appropriate.
2033 (e) Counseling and services for family planning to all
2034 women and their partners.
2035 (f) A scheduled postpartum visit for the purpose of
2036 voluntary family planning, to include discussion of all methods
2037 of contraception, as appropriate.
2038 (g) Referral to the Special Supplemental Nutrition Program
2039 for Women, Infants, and Children (WIC).
2040 (36) Any entity that provides Medicaid prepaid health plan
2041 services shall ensure the appropriate coordination of health
2042 care services with an assisted living facility in cases where a
2043 Medicaid recipient is both a member of the entity's prepaid
2044 health plan and a resident of the assisted living facility. If
2045 the entity is at risk for Medicaid targeted case management and
2046 behavioral health services, the entity shall inform the assisted
2047 living facility of the procedures to follow should an emergent
2048 condition arise.
2049 (37) The agency may seek and implement federal waivers
2050 necessary to provide for cost-effective purchasing of home
2051 health services, private duty nursing services, transportation,
2052 independent laboratory services, and durable medical equipment
2053 and supplies through competitive bidding pursuant to s. 287.057.
2054 The agency may request appropriate waivers from the federal
2055 Health Care Financing Administration in order to competitively
2056 bid such services. The agency may exclude providers not selected
2057 through the bidding process from the Medicaid provider network.
2058 (38) The Agency for Health Care Administration is directed
2059 to issue a request for proposal or intent to negotiate to

2060 implement on a demonstration basis an outpatient specialty
2061 services pilot project in a rural and urban county in the state.
2062 As used in this subsection, the term "outpatient specialty
2063 services" means clinical laboratory, diagnostic imaging, and
2064 specified home medical services to include durable medical
2065 equipment, prosthetics and orthotics, and infusion therapy.
2066 (a) The entity that is awarded the contract to provide
2067 Medicaid managed care outpatient specialty services must, at a
2068 minimum, meet the following criteria:
2069 1. The entity must be licensed by the Office of Insurance
2070 Regulation under part II of chapter 641.
2071 2. The entity must be experienced in providing outpatient
2072 specialty services.
2073 3. The entity must demonstrate to the satisfaction of the
2074 agency that it provides high-quality services to its patients.
2075 4. The entity must demonstrate that it has in place a
2076 complaints and grievance process to assist Medicaid recipients
2077 enrolled in the pilot managed care program to resolve complaints
2078 and grievances.
2079 (b) The pilot managed care program shall operate for a
2080 period of 3 years. The objective of the pilot program shall be
2081 to determine the cost-effectiveness and effects on utilization,
2082 access, and quality of providing outpatient specialty services
2083 to Medicaid recipients on a prepaid, capitated basis.
2084 (c) The agency shall conduct a quality assurance review of
2085 the prepaid health clinic each year that the demonstration
2086 program is in effect. The prepaid health clinic is responsible
2087 for all expenses incurred by the agency in conducting a quality
2088 assurance review.

2089 (d) The entity that is awarded the contract to provide
2090 outpatient specialty services to Medicaid recipients shall
2091 report data required by the agency in a format specified by the
2092 agency, for the purpose of conducting the evaluation required in
2093 paragraph (e).
2094 (e) The agency shall conduct an evaluation of the pilot
2095 managed care program and report its findings to the Governor and
2096 the Legislature by no later than January 1, 2001.
2097 (39) The agency shall enter into agreements with not-for-
2098 profit organizations based in this state for the purpose of
2099 providing vision screening.
2100 (40)(a) The agency shall implement a Medicaid prescribed-
2101 drug spending-control program that includes the following
2102 components:
2103 1. Medicaid prescribed-drug coverage for brand-name drugs
2104 for adult Medicaid recipients is limited to the dispensing of
2105 four brand-name drugs per month per recipient. Children are
2106 exempt from this restriction. Antiretroviral agents are excluded
2107 from this limitation. No requirements for prior authorization or
2108 other restrictions on medications used to treat mental illnesses
2109 such as schizophrenia, severe depression, or bipolar disorder
2110 may be imposed on Medicaid recipients. Medications that will be
2111 available without restriction for persons with mental illnesses
2112 include atypical antipsychotic medications, conventional
2113 antipsychotic medications, selective serotonin reuptake
2114 inhibitors, and other medications used for the treatment of
2115 serious mental illnesses. The agency shall also limit the amount
2116 of a prescribed drug dispensed to no more than a 34-day supply.
2117 The agency shall continue to provide unlimited generic drugs,

2118 contraceptive drugs and items, and diabetic supplies. Although a
2119 drug may be included on the preferred drug formulary, it would
2120 not be exempt from the four-brand limit. The agency may
2121 authorize exceptions to the brand-name-drug restriction based
2122 upon the treatment needs of the patients, only when such
2123 exceptions are based on prior consultation provided by the
2124 agency or an agency contractor, but the agency must establish
2125 procedures to ensure that:
2126 a. There will be a response to a request for prior
2127 consultation by telephone or other telecommunication device
2128 within 24 hours after receipt of a request for prior
2129 consultation;
2130 b. A 72-hour supply of the drug prescribed will be
2131 provided in an emergency or when the agency does not provide a
2132 response within 24 hours as required by sub-subparagraph a.; and
2133 c. Except for the exception for nursing home residents and
2134 other institutionalized adults and except for drugs on the
2135 restricted formulary for which prior authorization may be sought
2136 by an institutional or community pharmacy, prior authorization
2137 for an exception to the brand-name-drug restriction is sought by
2138 the prescriber and not by the pharmacy. When prior authorization
2139 is granted for a patient in an institutional setting beyond the
2140 brand-name-drug restriction, such approval is authorized for 12
2141 months and monthly prior authorization is not required for that
2142 patient.
2143 2. Reimbursement to pharmacies for Medicaid prescribed
2144 drugs shall be set at <u>the lesser of: the average wholesale price</u>
2145 <u>(AWP) minus 15.4 percent, the wholesaler acquisition cost (WAC)</u>
2146 <u>plus 5.75 percent, the federal upper limit (FUL), the state</u>

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2147 maximum allowable cost (SMAC), or the usual and customary (UAC)
2148 charge billed by the provider ~~the average wholesale price less~~
2149 ~~13.25 percent~~.
2150 3. The agency shall develop and implement a process for
2151 managing the drug therapies of Medicaid recipients who are using
2152 significant numbers of prescribed drugs each month. The
2153 management process may include, but is not limited to,
2154 comprehensive, physician-directed medical-record reviews, claims
2155 analyses, and case evaluations to determine the medical
2156 necessity and appropriateness of a patient's treatment plan and
2157 drug therapies. The agency may contract with a private
2158 organization to provide drug-program-management services. The
2159 Medicaid drug benefit management program shall include
2160 initiatives to manage drug therapies for HIV/AIDS patients,
2161 patients using 20 or more unique prescriptions in a 180-day
2162 period, and the top 1,000 patients in annual spending.
2163 4. The agency may limit the size of its pharmacy network
2164 based on need, competitive bidding, price negotiations,
2165 credentialing, or similar criteria. The agency shall give
2166 special consideration to rural areas in determining the size and
2167 location of pharmacies included in the Medicaid pharmacy
2168 network. A pharmacy credentialing process may include criteria
2169 such as a pharmacy's full-service status, location, size,
2170 patient educational programs, patient consultation, disease-
2171 management services, and other characteristics. The agency may
2172 impose a moratorium on Medicaid pharmacy enrollment when it is
2173 determined that it has a sufficient number of Medicaid-
2174 participating providers.
2175 5. The agency shall develop and implement a program that

2176 requires Medicaid practitioners who prescribe drugs to use a
2177 counterfeit-proof prescription pad for Medicaid prescriptions.
2178 The agency shall require the use of standardized counterfeit-
2179 proof prescription pads by Medicaid-participating prescribers or
2180 prescribers who write prescriptions for Medicaid recipients. The
2181 agency may implement the program in targeted geographic areas or
2182 statewide.
2183 6. The agency may enter into arrangements that require
2184 manufacturers of generic drugs prescribed to Medicaid recipients
2185 to provide rebates of at least 15.1 percent of the average
2186 manufacturer price for the manufacturer's generic products.
2187 These arrangements shall require that if a generic-drug
2188 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2189 at a level below 15.1 percent, the manufacturer must provide a
2190 supplemental rebate to the state in an amount necessary to
2191 achieve a 15.1-percent rebate level.
2192 7. The agency may establish a preferred drug formulary in
2193 accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the
2194 establishment of such formulary, it is authorized to negotiate
2195 supplemental rebates from manufacturers that are in addition to
2196 those required by Title XIX of the Social Security Act and at no
2197 less than 14 ~~10~~ percent of the average manufacturer price as
2198 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2199 the federal or supplemental rebate, or both, equals or exceeds
2200 29 ~~25~~ percent. There is no upper limit on the supplemental
2201 rebates the agency may negotiate. The agency may determine that
2202 specific products, brand-name or generic, are competitive at
2203 lower rebate percentages. Agreement to pay the minimum
2204 supplemental rebate percentage will guarantee a manufacturer

2205 that the Medicaid Pharmaceutical and Therapeutics Committee will
2206 consider a product for inclusion on the preferred drug
2207 formulary. However, a pharmaceutical manufacturer is not
2208 guaranteed placement on the formulary by simply paying the
2209 minimum supplemental rebate. Agency decisions will be made on
2210 the clinical efficacy of a drug and recommendations of the
2211 Medicaid Pharmaceutical and Therapeutics Committee, as well as
2212 the price of competing products minus federal and state rebates.
2213 The agency is authorized to contract with an outside agency or
2214 contractor to conduct negotiations for supplemental rebates. For
2215 the purposes of this section, the term "supplemental rebates"
2216 means ~~may include, at the agency's discretion,~~ cash rebates ~~and~~
2217 ~~other program benefits that offset a Medicaid expenditure~~.
2218 Effective July 1, 2004, value-added programs as a substitution
2219 for supplemental rebates are prohibited. ~~Such other program~~
2220 ~~benefits may include, but are not limited to, disease management~~
2221 ~~programs, drug product donation programs, drug utilization~~
2222 ~~control programs, prescriber and beneficiary counseling and~~
2223 ~~education, fraud and abuse initiatives, and other services or~~
2224 ~~administrative investments with guaranteed savings to the~~
2225 ~~Medicaid program in the same year the rebate reduction is~~
2226 ~~included in the General Appropriations Act.~~ The agency is
2227 authorized to seek any federal waivers to implement this
2228 initiative.
2229 8. The agency shall establish an advisory committee for
2230 the purposes of studying the feasibility of using a restricted
2231 drug formulary for nursing home residents and other
2232 institutionalized adults. The committee shall be comprised of
2233 seven members appointed by the Secretary of Health Care

2234 Administration. The committee members shall include two
2235 physicians licensed under chapter 458 or chapter 459; three
2236 pharmacists licensed under chapter 465 and appointed from a list
2237 of recommendations provided by the Florida Long-Term Care
2238 Pharmacy Alliance; and two pharmacists licensed under chapter
2239 465.

2240 9. The Agency for Health Care Administration shall expand
2241 home delivery of pharmacy products. To assist Medicaid patients
2242 in securing their prescriptions and reduce program costs, the
2243 agency shall expand its current mail-order-pharmacy diabetes-
2244 supply program to include all generic and brand-name drugs used
2245 by Medicaid patients with diabetes. Medicaid recipients in the
2246 current program may obtain nondiabetes drugs on a voluntary
2247 basis. This initiative is limited to the geographic area covered
2248 by the current contract. The agency may seek and implement any
2249 federal waivers necessary to implement this subparagraph.

2250 10. The agency shall limit to one dose per month any drug
2251 prescribed to treat erectile dysfunction.

2252 11.a. The agency shall implement a Medicaid behavioral
2253 drug management system. The agency may contract with a vendor
2254 that has experience in operating behavioral drug management
2255 systems to implement this program. The agency is authorized to
2256 seek federal waivers to implement this program.

2257 b. The agency, in conjunction with the Department of
2258 Children and Family Services, may implement the Medicaid
2259 behavioral drug management system that is designed to improve
2260 the quality of care and behavioral health prescribing practices
2261 based on best practice guidelines, improve patient adherence to
2262 medication plans, reduce clinical risk, and lower prescribed

2263 drug costs and the rate of inappropriate spending on Medicaid
2264 behavioral drugs. The program shall include the following
2265 elements:
2266 (I) Provide for the development and adoption of best
2267 practice guidelines for behavioral health-related drugs such as
2268 antipsychotics, antidepressants, and medications for treating
2269 bipolar disorders and other behavioral conditions; translate
2270 them into practice; review behavioral health prescribers and
2271 compare their prescribing patterns to a number of indicators
2272 that are based on national standards; and determine deviations
2273 from best practice guidelines.
2274 (II) Implement processes for providing feedback to and
2275 educating prescribers using best practice educational materials
2276 and peer-to-peer consultation.
2277 (III) Assess Medicaid beneficiaries who are outliers in
2278 their use of behavioral health drugs with regard to the numbers
2279 and types of drugs taken, drug dosages, combination drug
2280 therapies, and other indicators of improper use of behavioral
2281 health drugs.
2282 (IV) Alert prescribers to patients who fail to refill
2283 prescriptions in a timely fashion, are prescribed multiple same-
2284 class behavioral health drugs, and may have other potential
2285 medication problems.
2286 (V) Track spending trends for behavioral health drugs and
2287 deviation from best practice guidelines.
2288 (VI) Use educational and technological approaches to
2289 promote best practices, educate consumers, and train prescribers
2290 in the use of practice guidelines.
2291 (VII) Disseminate electronic and published materials.

2292 (VIII) Hold statewide and regional conferences.
2293 (IX) Implement a disease management program with a model
2294 quality-based medication component for severely mentally ill
2295 individuals and emotionally disturbed children who are high
2296 users of care.
2297 c. If the agency is unable to negotiate a contract with
2298 one or more manufacturers to finance and guarantee savings
2299 associated with a behavioral drug management program by
2300 September 1, 2004, the four-brand drug limit and preferred drug
2301 list prior-authorization requirements shall apply to mental-
2302 health-related drugs, notwithstanding any provision in
2303 subparagraph 1. The agency is authorized to seek federal waivers
2304 to implement this policy.
2305 12. The agency is authorized to contract for drug rebate
2306 administration, including, but not limited to, calculating
2307 rebate amounts, invoicing manufacturers, negotiating disputes
2308 with manufacturers, and maintaining a database of rebate
2309 collections.
2310 13. The agency may specify the preferred daily dosing form
2311 or strength for the purpose of promoting best practices with
2312 regard to the prescribing of certain drugs as specified in the
2313 General Appropriations Act and ensuring cost-effective
2314 prescribing practices.
2315 14. The agency may require prior authorization for the
2316 off-label use of Medicaid-covered prescribed drugs as specified
2317 in the General Appropriations Act. The agency may, but is not
2318 required to, preauthorize the use of a product for an indication
2319 not in the approved labeling. Prior authorization may require
2320 the prescribing professional to provide information about the

2321 rationale and supporting medical evidence for the off-label use
2322 of a drug.
2323 15. The agency shall implement a return and reuse program
2324 for drugs dispensed by pharmacies to institutional recipients,
2325 which includes payment of a $5 restocking fee for the
2326 implementation and operation of the program. The return and
2327 reuse program shall be implemented electronically and in a
2328 manner that promotes efficiency. The program must permit a
2329 pharmacy to exclude drugs from the program if it is not
2330 practical or cost-effective for the drug to be included and must
2331 provide for the return to inventory of drugs that cannot be
2332 credited or returned in a cost-effective manner.
2333 (b) The agency shall implement this subsection to the
2334 extent that funds are appropriated to administer the Medicaid
2335 prescribed-drug spending-control program. The agency may
2336 contract all or any part of this program to private
2337 organizations.
2338 (c) The agency shall submit quarterly reports to the
2339 Governor, the President of the Senate, and the Speaker of the
2340 House of Representatives which must include, but need not be
2341 limited to, the progress made in implementing this subsection
2342 and its effect on Medicaid prescribed-drug expenditures.
2343 (41) Notwithstanding the provisions of chapter 287, the
2344 agency may, at its discretion, renew a contract or contracts for
2345 fiscal intermediary services one or more times for such periods
2346 as the agency may decide; however, all such renewals may not
2347 combine to exceed a total period longer than the term of the
2348 original contract.
2349 (42) The agency shall provide for the development of a

2350 demonstration project by establishment in Miami-Dade County of a
2351 long-term-care facility licensed pursuant to chapter 395 to
2352 improve access to health care for a predominantly minority,
2353 medically underserved, and medically complex population and to
2354 evaluate alternatives to nursing home care and general acute
2355 care for such population. Such project is to be located in a
2356 health care condominium and colocated with licensed facilities
2357 providing a continuum of care. The establishment of this project
2358 is not subject to the provisions of s. 408.036 or s. 408.039.
2359 The agency shall report its findings to the Governor, the
2360 President of the Senate, and the Speaker of the House of
2361 Representatives by January 1, 2003.
2362 (43) The agency shall develop and implement a utilization
2363 management program for Medicaid-eligible recipients for the
2364 management of occupational, physical, respiratory, and speech
2365 therapies. The agency shall establish a utilization program that
2366 may require prior authorization in order to ensure medically
2367 necessary and cost-effective treatments. The program shall be
2368 operated in accordance with a federally approved waiver program
2369 or state plan amendment. The agency may seek a federal waiver or
2370 state plan amendment to implement this program. The agency may
2371 also competitively procure these services from an outside vendor
2372 on a regional or statewide basis.
2373 (44) The agency may contract on a prepaid or fixed-sum
2374 basis with appropriately licensed prepaid dental health plans to
2375 provide dental services.
2376 (45) The Agency for Health Care Administration shall
2377 ensure that any Medicaid managed care plan as defined in s.
2378 409.9122(2)(h), whether paid on a capitated basis or a shared

2379 savings basis, is cost-effective. For purposes of this
2380 subsection, the term "cost-effective" means that a network's
2381 per-member, per-month costs to the state, including, but not
2382 limited to, fee-for-service costs, administrative costs, and
2383 case-management fees, must be no greater than the state's costs
2384 associated with contracts for Medicaid services established
2385 under subsection (3), which shall be actuarially adjusted for
2386 case mix, model, and service area. The agency shall conduct
2387 actuarially sound audits adjusted for case mix and model in
2388 order to ensure such cost-effectiveness and shall publish the
2389 audit results on its Internet website and submit the audit
2390 results annually to the Governor, the President of the Senate,
2391 and the Speaker of the House of Representatives no later than
2392 December 31 of each year. Contracts established pursuant to this
2393 subsection which are not cost-effective may not be renewed.
2394 Section 18. Paragraphs (a) and (e) of subsection (2) of
2395 section 409.9122, Florida Statutes, are amended, and subsection
2396 (14) is added to said section, to read:
2397 409.9122 Mandatory Medicaid managed care enrollment;
2398 programs and procedures.--
2399 (2)(a) The agency shall enroll in a managed care plan or
2400 MediPass all Medicaid recipients, except those Medicaid
2401 recipients who are: in an institution; enrolled in the Medicaid
2402 medically needy program; or eligible for both Medicaid and
2403 Medicare. Upon enrollment, individuals will be able to change
2404 their managed care option during the 90-day opt out period
2405 required by federal Medicaid regulations. The agency is
2406 authorized to seek the necessary Medicaid state plan amendment
2407 to implement this policy. However, to the extent permitted by

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2408 federal law, the agency may enroll in a managed care plan or
2409 MediPass a Medicaid recipient who is exempt from mandatory
2410 managed care enrollment, provided that:
2411 1. The recipient's decision to enroll in a managed care
2412 plan or MediPass is voluntary;
2413 2. If the recipient chooses to enroll in a managed care
2414 plan, the agency has determined that the managed care plan
2415 provides specific programs and services which address the
2416 special health needs of the recipient; and
2417 3. The agency receives any necessary waivers from the
2418 federal Health Care Financing Administration.
2419
2420 The agency shall develop rules to establish policies by which
2421 exceptions to the mandatory managed care enrollment requirement
2422 may be made on a case-by-case basis. The rules shall include the
2423 specific criteria to be applied when making a determination as
2424 to whether to exempt a recipient from mandatory enrollment in a
2425 managed care plan or MediPass. School districts participating in
2426 the certified school match program pursuant to ss. 409.908(21)
2427 and 1011.70 shall be reimbursed by Medicaid, subject to the
2428 limitations of s. 1011.70(1), for a Medicaid-eligible child
2429 participating in the services as authorized in s. 1011.70, as
2430 provided for in s. 409.9071, regardless of whether the child is
2431 enrolled in MediPass or a managed care plan. Managed care plans
2432 shall make a good faith effort to execute agreements with school
2433 districts regarding the coordinated provision of services
2434 authorized under s. 1011.70. County health departments
2435 delivering school-based services pursuant to ss. 381.0056 and
2436 381.0057 shall be reimbursed by Medicaid for the federal share

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2437 for a Medicaid-eligible child who receives Medicaid-covered
2438 services in a school setting, regardless of whether the child is
2439 enrolled in MediPass or a managed care plan. Managed care plans
2440 shall make a good faith effort to execute agreements with county
2441 health departments regarding the coordinated provision of
2442 services to a Medicaid-eligible child. To ensure continuity of
2443 care for Medicaid patients, the agency, the Department of
2444 Health, and the Department of Education shall develop procedures
2445 for ensuring that a student's managed care plan or MediPass
2446 provider receives information relating to services provided in
2447 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
2448 (e) Medicaid recipients who are already enrolled in a
2449 managed care plan or MediPass shall be offered the opportunity
2450 to change managed care plans or MediPass providers on a
2451 staggered basis, as defined by the agency. All Medicaid
2452 recipients shall have 30 ~~90~~ days in which to make a choice of
2453 managed care plans or MediPass providers. Those Medicaid
2454 recipients who do not make a choice shall be assigned to a
2455 managed care plan or MediPass in accordance with paragraph (f).
2456 To facilitate continuity of care, for a Medicaid recipient who
2457 is also a recipient of Supplemental Security Income (SSI), prior
2458 to assigning the SSI recipient to a managed care plan or
2459 MediPass, the agency shall determine whether the SSI recipient
2460 has an ongoing relationship with a MediPass provider or managed
2461 care plan, and if so, the agency shall assign the SSI recipient
2462 to that MediPass provider or managed care plan. Those SSI
2463 recipients who do not have such a provider relationship shall be
2464 assigned to a managed care plan or MediPass provider in
2465 accordance with paragraph (f).

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2466 (14) The agency shall include in its calculation of the
2467 hospital inpatient component of a Medicaid health maintenance
2468 organization's capitation rate any special payments, including,
2469 but not limited to, upper payment limit or disproportionate
2470 share hospital payments, made to qualifying hospitals through
2471 the fee-for-service program. The agency may seek federal waiver
2472 approval or state plan amendment as needed to implement this
2473 adjustment.
2474 Section 19. Section 409.9124, Florida Statutes, is amended
2475 to read:
2476 409.9124 Managed care reimbursement.--
2477 (1) The agency shall develop and adopt by rule a
2478 methodology for reimbursing managed care plans.
2479 (2) Final rates shall be published annually prior to
2480 September 1 of each year, based on methodology that:
2481 (a) Uses Medicaid's fee-for-service expenditures.
2482 (b) Is certified as an actuarially sound computation of
2483 Medicaid fee-for-service expenditures for comparable groups of
2484 Medicaid recipients and includes all fee-for-service
2485 expenditures, including those fee-for-service expenditures
2486 attributable to recipients who are enrolled for a portion of a
2487 year in a managed care plan or waiver program.
2488 (c) Is compliant with applicable federal laws and
2489 regulations, including, but not limited to, the requirements to
2490 include an allowance for administrative expenses and to account
2491 for all fee-for service expenditures, including fee-for-service
2492 expenditures for those groups enrolled for part of a year.
2493 (3) Each year prior to establishing new managed care
2494 rates, the agency shall review all prior year adjustments for

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2495 changes in trend, and shall reduce or eliminate those
2496 adjustments which are not reasonable and which reflect policies
2497 or programs which are not in effect.
2498 (4)~~(2)~~ The agency shall by rule prescribe those items of
2499 financial information which each managed care plan shall report
2500 to the agency, in the time periods prescribed by rule. In
2501 prescribing items for reporting and definitions of terms, the
2502 agency shall consult with the Office of Insurance Regulation of
2503 the Financial Services Commission wherever possible.
2504 (5)~~(3)~~ The agency shall quarterly examine the financial
2505 condition of each managed care plan, and its performance in
2506 serving Medicaid patients, and shall utilize examinations
2507 performed by the Office of Insurance Regulation wherever
2508 possible.
2509 Section 20. Paragraph (b) of subsection (5) of section
2510 624.91, Florida Statutes, as amended by chapter 2004-1, Laws of
2511 Florida, is amended to read:
2512 624.91 The Florida Healthy Kids Corporation Act.--
2513 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.--
2514 (b) The Florida Healthy Kids Corporation shall:
2515 1. Arrange for the collection of any family, local
2516 contributions, or employer payment or premium, in an amount to
2517 be determined by the board of directors, to provide for payment
2518 of premiums for comprehensive insurance coverage and for the
2519 actual or estimated administrative expenses.
2520 2. Arrange for the collection of any voluntary
2521 contributions to provide for payment of premiums for children
2522 who are not eligible for medical assistance under Title XXI of
2523 the Social Security Act. Each fiscal year, the corporation shall

2524 establish a local match policy for the enrollment of non-Title-
2525 XXI-eligible children in the Healthy Kids program. By May 1 of
2526 each year, the corporation shall provide written notification of
2527 the amount to be remitted to the corporation for the following
2528 fiscal year under that policy. Local match sources may include,
2529 but are not limited to, funds provided by municipalities,
2530 counties, school boards, hospitals, health care providers,
2531 charitable organizations, special taxing districts, and private
2532 organizations. The minimum local match cash contributions
2533 required each fiscal year and local match credits shall be
2534 determined by the General Appropriations Act. The corporation
2535 shall calculate a county's local match rate based upon that
2536 county's percentage of the state's total non-Title-XXI
2537 expenditures as reported in the corporation's most recently
2538 audited financial statement. In awarding the local match
2539 credits, the corporation may consider factors including, but not
2540 limited to, population density, per capita income, and existing
2541 child-health-related expenditures and services.

2542 3. Subject to the provisions of s. 409.8134, accept
2543 voluntary supplemental local match contributions that comply
2544 with the requirements of Title XXI of the Social Security Act
2545 for the purpose of providing additional coverage in contributing
2546 counties under Title XXI.

2547 4. Establish the administrative and accounting procedures
2548 for the operation of the corporation.

2549 5. Establish, with consultation from appropriate
2550 professional organizations, standards for preventive health
2551 services and providers and comprehensive insurance benefits
2552 appropriate to children, provided that such standards for rural

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2553 areas shall not limit primary care providers to board-certified
2554 pediatricians.
2555 6. Determine eligibility for children seeking to
2556 participate in the Title XXI-funded components of the Florida
2557 KidCare program consistent with the requirements specified in s.
2558 409.814, as well as the non-Title-XXI-eligible children as
2559 provided in subsection (3).
2560 7. Establish procedures under which providers of local
2561 match to, applicants to and participants in the program may have
2562 grievances reviewed by an impartial body and reported to the
2563 board of directors of the corporation.
2564 8. Establish participation criteria and, if appropriate,
2565 contract with an authorized insurer, health maintenance
2566 organization, or third-party administrator to provide
2567 administrative services to the corporation.
2568 9. Establish enrollment criteria which shall include
2569 penalties or waiting periods of not fewer than 60 days for
2570 reinstatement of coverage upon voluntary cancellation for
2571 nonpayment of family premiums.
2572 10. Contract with authorized insurers or any provider of
2573 health care services, meeting standards established by the
2574 corporation, for the provision of comprehensive insurance
2575 coverage to participants. Such standards shall include criteria
2576 under which the corporation may contract with more than one
2577 provider of health care services in program sites. Health plans
2578 shall be selected through a competitive bid process. The Florida
2579 Healthy Kids Corporation shall purchase goods and services in
2580 the most cost-effective manner consistent with the delivery of
2581 quality medical care. The maximum administrative cost for a

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2582 Florida Healthy Kids Corporation contract shall be 15 percent.
2583 For health care contracts, the minimum medical loss ratio for a
2584 Florida Healthy Kids Corporation contract shall be 85 percent.
2585 For dental contracts, the remaining compensation to be paid to
2586 the authorized insurer or provider under a Florida Healthy Kids
2587 Corporation contract shall be no less than an amount which is 85
2588 percent of premium; to the extent any contract provision does
2589 not provide for this minimum compensation, this section shall
2590 prevail. The health plan selection criteria and scoring system,
2591 and the scoring results, shall be available upon request for
2592 inspection after the bids have been awarded.
2593 11. Establish disenrollment criteria in the event local
2594 matching funds are insufficient to cover enrollments.
2595 12. Develop and implement a plan to publicize the Florida
2596 Healthy Kids Corporation, the eligibility requirements of the
2597 program, and the procedures for enrollment in the program and to
2598 maintain public awareness of the corporation and the program.
2599 13. Secure staff necessary to properly administer the
2600 corporation. Staff costs shall be funded from state and local
2601 matching funds and such other private or public funds as become
2602 available. The board of directors shall determine the number of
2603 staff members necessary to administer the corporation.
2604 14. Provide a report annually to the Governor, Chief
2605 Financial Officer, Commissioner of Education, Senate President,
2606 Speaker of the House of Representatives, and Minority Leaders of
2607 the Senate and the House of Representatives.
2608 15. Establish benefit packages which conform to the
2609 provisions of the Florida KidCare program, as created in ss.
2610 409.810-409.820.

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2611 Section 21. Notwithstanding s. 430.707, Florida Statutes,
2612 no later than September 1, 2005, subject to federal approval of
2613 the application to be a Program of All-inclusive Care for the
2614 Elderly site, the agency shall contract with one private, not-
2615 for-profit hospice organization located in Lee County and one
2616 such organization in Martin County, such an entity shall be
2617 exempt from the requirements of chapter 641 Florida Statutes,
2618 each of which provides comprehensive services, including hospice
2619 care for frail and elderly persons. The agency shall approve 100
2620 initial enrollees in the Program of All-inclusive Care for the
2621 Elderly in Lee and Martin counties. There shall be 50 initial
2622 enrollees in each county.
2623 Section 22. In order to improve affordability and provide
2624 coverage for more facilities for residents of the state, the
2625 agency shall renegotiate the terms, conditions, and duration of
2626 its loan to the Long Term Care Risk Retention Group to provide
2627 that participating skilled nursing facilities be required to pay
2628 no more than $65 per bed for capitalization costs and
2629 participating adult living facilities will be required to pay no
2630 more than $33 per bed for capitalization costs.
2631 Section 23. The Office of Program Policy Analysis and
2632 Government Accountability shall perform a review of optional
2633 Medicaid coverage for pregnant women, adult dentures, and the
2634 medically needy. The review shall determine the cost benefit to
2635 the state of providing these optional Medicaid items to Medicaid
2636 recipients. A report on the findings of the review shall be
2637 provided to the Executive Office of the Governor, the President
2638 of the Senate, and the Speaker of the House of Representatives
2639 by February 1, 2005.

2640 Section 24. The Agency for Health Care Administration may
2641 contract on a capitated, prepaid, or fixed-sum basis with a
2642 laboratory service provider to provide statewide laboratory
2643 services for Medicaid recipients. The contract is not subject to
2644 any requirement of the Florida Insurance Code. Whether or not
2645 the agency procures statewide laboratory services, the agency
2646 shall ensure that it secures laboratory values from Medicaid-
2647 enrolled laboratories for all tests provided to Medicaid
2648 recipients. Such data shall be included in the Medicaid real-
2649 time web-based reporting system that interfaces with a real-time
2650 web-based prescription ordering and tracking system as required
2651 by the 2003-2004 General Appropriations Act.
2652 Section 25. Except as otherwise provided herein, this act
2653 shall take effect July 1, 2004.
2654