CHAPTER 2005-133

Committee Substitute for
Committee Substitute for Senate Bill No. 838

An act relating to Medicaid; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to contract with a vendor to monitor and evaluate the clinical practice patterns of providers; authorizing the agency to competitively bid for single-source providers for certain services; authorizing the agency to examine whether purchasing certain durable medical equipment is more cost-effective than long-term rental of such equipment; providing that a contract awarded to a provider service network remains in effect for a certain period; defining a provider service network; providing health care providers with a controlling interest in the governing body of the provider service network organization; requiring that the agency, in partnership with the Department of Elderly Affairs, develop an integrated, fixed-payment delivery system for Medicaid recipients age 60 and older; requiring the Office of Program Policy Analysis and Government Accountability to conduct an evaluation; deleting an obsolete provision requiring the agency to develop a plan for implementing emergency and crisis care; requiring the agency to develop a system where health care vendors may provide a business case demonstrating that higher reimbursement for a good or service will be offset by cost savings in other goods or services; requiring the Comprehensive Assessment and Review for Long-Term Care Services (CARES) teams to consult with any person making a determination that a nursing home resident funded by Medicare is not making progress toward rehabilitation and assist in any appeals of the decision; requiring the agency to contract with an entity to design a clinical-utilization information database or electronic medical record for Medicaid providers; requiring the agency to coordinate with other entities to create emergency room diversion programs for Medicaid recipients; allowing dispensing practitioners to participate in Medicaid; requiring that the agency implement a Medicaid prescription-drug-management system; requiring the agency to determine the extent that prescription drugs are returned and reused in institutional settings and whether this program could be expanded; authorizing the agency to pay for emergency mental health services provided through licensed crisis-stabilization facilities; creating s. 409.91211, F.S.; specifying waiver authority for the Agency for Health Care Administration to establish a Medicaid reform program contingent on federal approval to preserve the upper-payment-limit finding mechanism for hospitals and contingent on protection of the disproportionate share program authorized pursuant to ch. 409, F.S.; providing legislative intent; providing powers, duties, and responsibilities of the agency under the pilot program; requiring that the agency submit any waivers to the Legislature for approval before implementation; allowing the agency to develop rules; requiring that the Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, evaluate the pilot

program and report to the Governor and the Legislature on whether it should be expanded statewide; amending s. 409.9062, F.S.; requiring the Agency for Health Care Administration to reimburse lung transplant facilities a global fee for services provided to Medicaid recipients; providing an appropriation; amending s. 409.9122, F.S.; revising a reference; amending s. 409.913, F.S.; requiring 5 percent of all program integrity audits to be conducted on a random basis; requiring that Medicaid recipients be provided with an explanation of benefits; requiring that the agency report to the Legislature on the legal and administrative barriers to enforcing the copayment requirements of s. 409.9081, F.S.; requiring the agency to recommend ways to ensure that Medicaid is the payer of last resort; requiring the Office of Program Policy Analysis and Government Accountability to conduct a study of the long-term care diversion programs; requiring the agency to determine how many individuals in long-term care diversion programs have a patient payment responsibility that is not being collected and to recommend how to collect such payments; requiring the Office of Program Policy Analysis and Government Accountability to conduct a study of Medicaid buy-in programs to determine if these programs can be created in this state without expanding the overall Medicaid program budget or if the Medically Needy program can be changed into a Medicaid buy-in program; providing an appropriation and authorizing positions to implement this act; requiring the Office of Program Policy Analysis and Government Accountability, in consultation with the Office of Attorney General and the Auditor General, to conduct a study to examine whether state and federal dollars are lost due to fraud and abuse in the Medicaid prescription drug program; providing duties; requiring that a report with findings and recommendations be submitted to the Governor and the Legislature by a specified date; repealing the amendments made to ss. 393.0661, 409.907, and 409.9082, F.S., and the amendments made to the introductory provision of s. 409.908, F.S., by the Conference Committee Report on CS for CS for SB 404, relating to provider agreements and provider methodologies; repealing s. 23 of the Conference Committee Report on CS for CS for SB 404, relating to legislative intent; amending s. 409.9124, F.S., as amended by the Conference Committee Report on CS for CS for SB 404; revising provisions requiring the Agency for Health Care Administration to pay certain rates for managed care reimbursement; requiring that the agency make an additional adjustment in calculating the rates paid to prepaid health plans for the 2005-2006 fiscal year; requiring that the Senate Select Committee on Medicaid Reform study various issues concerning Medicaid provider rates and issue a report to the Governor and the Legislature; providing an effective date.

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

Section 1. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective

manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may ~~is authorized to~~ seek federal waivers necessary to administer these policies ~~implement this policy~~.

(1) The agency shall work with the Department of Children and Family Services to ensure access of children and families in the child protection system to needed and appropriate mental health and substance abuse services.

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

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

(4) The agency may contract with:

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

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a managed care plan in an AHCA area. Each entity must offer sufficient choice of

providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

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

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan

must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency is authorized to seek any federal waivers to implement this initiative.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (17) and (18).

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract-expiration date, regardless of any contractual provisions to the contrary. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

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

(f) An entity that provides in-home physician services to test the cost-effectiveness of enhanced home-based medical care to Medicaid recipients

with degenerative neurological diseases and other diseases or disabling conditions associated with high costs to Medicaid. The program shall be designed to serve very disabled persons and to reduce Medicaid reimbursed costs for inpatient, outpatient, and emergency department services. The agency shall contract with vendors on a risk-sharing basis.

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

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

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

(5) By December 1, 2005, the Agency for Health Care Administration, in partnership with the Department of Elderly Affairs, shall create an integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older. The Agency for Health Care Administration shall implement the integrated system initially on a pilot basis in two areas of the state. In one of the areas enrollment shall be on a voluntary basis. The program must transfer all Medicaid services for eligible elderly individuals who choose to participate into an integrated-care management model designed to serve Medicaid recipients in the community. The program must combine all funding for Medicaid services provided to individuals 60 years of age or older into the integrated system, including funds for Medicaid home and community-based waiver services; all Medicaid services authorized in ss. 409.905 and 409.906, excluding funds for Medicaid nursing home services unless the agency is able to demonstrate how the integration of the funds will improve coordinated care for these services in a less costly manner; and Medicare coinsurance and deductibles for persons dually eligible for Medicaid and Medicare as prescribed in s. 409.908(13).

(a) Individuals who are 60 years of age or older and enrolled in the the developmental disabilities waiver program, the family and supported-living waiver program, the project AIDS care waiver program, the traumatic brain injury and spinal cord injury waiver program, the consumer-directed care waiver program, and the program of all-inclusive care for the elderly program, and residents of institutional care facilities for the developmentally disabled, must be excluded from the integrated system.

(b) The program must use a competitive-procurement process to select entities to operate the integrated system. Entities eligible to submit bids include managed care organizations licensed under chapter 641, including entities eligible to participate in the nursing home diversion program, other qualified providers as defined in s. 430.703(7), community care for the elderly lead agencies, and other state-certified community service networks that meet comparable standards as defined by the agency, in consultation with the Department of Elderly Affairs and the Office of Insurance Regulation, to be financially solvent and able to take on financial risk for managed care. Community service networks that are certified pursuant to the comparable standards defined by the agency are not required to be licensed under chapter 641.

(c) The agency must ensure that the capitation-rate-setting methodology for the integrated system is actuarially sound and reflects the intent to provide quality care in the least-restrictive setting. The agency must also require integrated-system providers to develop a credentialing system for service providers and to contract with all Gold Seal nursing homes, where feasible, and exclude, where feasible, chronically poor-performing facilities and providers as defined by the agency. The integrated system must provide that if the recipient resides in a noncontracted residential facility licensed under chapter 400 at the time the integrated system is initiated, the recipient must be permitted to continue to reside in the noncontracted facility as long as the recipient desires. The integrated system must also provide that, in the absence of a contract between the integrated-system provider and the residential facility licensed under chapter 400, current Medicaid rates must prevail. The agency and the Department of Elderly Affairs must jointly develop procedures to manage the services provided through the integrated system in order to ensure quality and recipient choice.

(d) Within 24 months after implementation, the Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, shall comprehensively evaluate the pilot project for the integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older. The evaluation must include assessments of cost savings; consumer education, choice, and access to services; coordination of care; and quality of care. The evaluation must describe administrative or legal barriers to the implementation and operation of the pilot program and include recommendations regarding statewide expansion of the pilot program. The office shall submit an evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than June 30, 2008.

(e) The agency may seek federal waivers and adopt rules as necessary to administer the integrated system. The agency must receive specific authorization from the Legislature prior to implementing the waiver for the integrated system. ~~By October 1, 2003, the agency and the department shall, to the extent feasible, develop a plan for implementing new Medicaid procedure codes for emergency and crisis care, supportive residential services, and other services designed to maximize the use of Medicaid funds for Medicaid-eligible recipients. The agency shall include in the agreement developed pursuant to subsection (4) a provision that ensures that the match~~

~~requirements for these new procedure codes are met by certifying eligible general revenue or local funds that are currently expended on these services by the department with contracted alcohol, drug abuse, and mental health providers. The plan must describe specific procedure codes to be implemented, a projection of the number of procedures to be delivered during fiscal year 2003-2004, and a financial analysis that describes the certified match procedures, and accountability mechanisms, projects the earnings associated with these procedures, and describes the sources of state match. This plan may not be implemented in any part until approved by the Legislative Budget Commission. If such approval has not occurred by December 31, 2003, the plan shall be submitted for consideration by the 2004 Legislature.~~

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

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

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

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

(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

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

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

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

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

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

(b) Assumes the underwriting risk; and

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

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

(9) The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization.

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

(a) Fraud;

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

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

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

(11) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

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

(b) Notwithstanding s. 216.292, funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid

waiver and are not expended shall be transferred to the agency to fund Medicaid-reimbursed nursing home care.

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

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

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

(b) The agency shall develop a procedure for determining whether health care providers and service vendors can provide the Medicaid program using a business case that demonstrates whether a particular good or service can offset the cost of providing the good or service in an alternative setting or through other means and therefore should receive a higher reimbursement. The business case must include, but need not be limited to:

1. A detailed description of the good or service to be provided, a description and analysis of the agency's current performance of the service, and a rationale documenting how providing the service in an alternative setting would be in the best interest of the state, the agency, and its clients.

2. A cost-benefit analysis documenting the estimated specific direct and indirect costs, savings, performance improvements, risks, and qualitative and quantitative benefits involved in or resulting from providing the service. The cost-benefit analysis must include a detailed plan and timeline identifying all actions that must be implemented to realize expected benefits. The Secretary of Health Care Administration shall verify that all costs, savings, and benefits are valid and achievable.

(c) If the agency determines that the increased reimbursement is cost-effective, the agency shall recommend a change in the reimbursement schedule for that particular good or service. If, within 12 months after implementing any rate change under this procedure, the agency determines that costs were not offset by the increased reimbursement schedule, the agency may revert to the former reimbursement schedule for the particular good or service.

(15)(a) The agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) nursing facility preadmission screening program to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. The CARES program shall also ensure that individuals participating in

Medicaid home and community-based waiver programs meet criteria for those programs, consistent with approved federal waivers.

(b) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly Affairs, may contract for any function or activity of the CARES program, including any function or activity required by 42 C.F.R. part 483.20, relating to preadmission screening and resident review.

(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the individual requires nursing facility care and that the individual cannot be safely served in community-based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program. For individuals whose nursing home stay is initially funded by Medicare and Medicare coverage is being terminated for lack of progress towards rehabilitation, CARES staff shall consult with the person making the determination of progress toward rehabilitation to ensure that the recipient is not being inappropriately disqualified from Medicare coverage. If, in their professional judgment, CARES staff believes that a Medicare beneficiary is still making progress toward rehabilitation, they may assist the Medicare beneficiary with an appeal of the disqualification from Medicare coverage. The use of CARES teams to review Medicare denials for coverage under this section is authorized only if it is determined that such reviews qualify for federal matching funds through Medicaid. The agency shall seek or amend federal waivers as necessary to implement this section.

(d) For the purpose of initiating immediate prescreening and diversion assistance for individuals residing in nursing homes and in order to make families aware of alternative long-term care resources so that they may choose a more cost-effective setting for long-term placement, CARES staff shall conduct an assessment and review of a sample of individuals whose nursing home stay is expected to exceed 20 days, regardless of the initial funding source for the nursing home placement. CARES staff shall provide counseling and referral services to these individuals regarding choosing appropriate long-term care alternatives. This paragraph does not apply to continuing care facilities licensed under chapter 651 or to retirement communities that provide a combination of nursing home, independent living, and other long-term care services.

(e) By January 15 of each year, the agency shall submit a report to the Legislature and the Office of Long-Term-Care Policy describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

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

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

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

(f) The Department of Elderly Affairs shall track individuals over time who are assessed under the CARES program and who are diverted from nursing home placement. By January 15 of each year, the department shall submit to the Legislature and the Office of Long-Term-Care Policy a longitudinal study of the individuals who are diverted from nursing home placement. The study must include:

1. The demographic characteristics of the individuals assessed and diverted from nursing home placement, including, but not limited to, age, race, gender, frailty, caregiver status, living arrangements, and geographic location;

2. A summary of community services provided to individuals for 1 year after assessment and diversion;

3. A summary of inpatient hospital admissions for individuals who have been diverted; and

4. A summary of the length of time between diversion and subsequent entry into a nursing home or death.

(g) By July 1, 2005, the department and the Agency for Health Care Administration shall report to the President of the Senate and the Speaker of the House of Representatives regarding the impact to the state of modifying level-of-care criteria to eliminate the Intermediate II level of care.

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

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

1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug

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

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

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

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

5. By April 1, 2006, the agency shall contract with an entity to design a database of clinical utilization information or electronic medical records for Medicaid providers. This system must be web-based and allow providers to review on a real-time basis the utilization of Medicaid services, including, but not limited to, physician office visits, inpatient and outpatient hospitalizations, laboratory and pathology services, radiological and other imaging services, dental care, and patterns of dispensing prescription drugs in order to coordinate care and identify potential fraud and abuse.

~~6.~~5. The agency may apply for any federal waivers needed to administer ~~implement~~ this paragraph.

(17) An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Office of Insurance Regulation, and restricted funds or deposits controlled by the agency or the Office of Insurance Regulation, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues. As used in this subsection, the

term "surplus" means the entity's total assets minus total liabilities. If an entity's surplus falls below an amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

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

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

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

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

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

(b) The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance that will protect enrollees if the entity becomes unable to meet its obligations.

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

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

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

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

(21) Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

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

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

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

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

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

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

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (24).

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

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in

an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

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

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

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

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

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

(27) The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality

assurance reform initiative. The system shall include, but need not be limited to, the following:

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

1. Written quality assurance program descriptions.

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

3. An active quality assurance committee.

4. Quality assurance program supervision.

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

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

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

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

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

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

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

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

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

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

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

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

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

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

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

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

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

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

(29) The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (21)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but

shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract.

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

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

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

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

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

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

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

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

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

(33) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs.

(34) The agency and entities that ~~which~~ contract with the agency to provide health care services to Medicaid recipients under this section or ss. 409.91211 and ~~s.~~ 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients. Where feasible, safe, and cost-effective, the agency shall encourage hospitals, emergency medical services providers, and other public and private health care providers to work together in their local communities to enter into agreements or arrangements to ensure access to alternatives to emergency services and care for those Medicaid recipients who need nonemergent care. The agency shall coordinate with hospitals, emergency medical services providers, private health plans, capitated managed care networks as established in s. 409.91211, and other public and private health care providers to implement the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405, and 641.31097 to develop and implement emergency department diversion programs for Medicaid recipients.

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

(a) Healthy Start prenatal or infant screening.

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

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

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

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

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

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

(36) Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted

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

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

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

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

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

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

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

c. Except for the exception for nursing home residents and other institutionalized adults and except for drugs on the restricted formulary for which prior authorization may be sought by an institutional or community pharmacy, prior authorization for an exception to the brand-name-drug restric-

tion is sought by the prescriber and not by the pharmacy. When prior authorization is granted for a patient in an institutional setting beyond the brand-name-drug restriction, such approval is authorized for 12 months and monthly prior authorization is not required for that patient.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: the average wholesale price (AWP) minus 15.4 percent, the wholesaler acquisition cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

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

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease-management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers. <u>The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.</u>

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

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's

generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Effective July 1, 2004, value-added programs as a substitution for supplemental rebates are prohibited. The agency is authorized to seek any federal waivers to implement this initiative.

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

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

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

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

b. The agency, in conjunction with the Department of Children and Family Services, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program shall include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

c. If the agency is unable to negotiate a contract with one or more manufacturers to finance and guarantee savings associated with a behavioral drug management program by September 1, 2004, the four-brand drug limit

and preferred drug list prior-authorization requirements shall apply to mental health-related drugs, notwithstanding any provision in subparagraph 1. The agency is authorized to seek federal waivers to implement this policy.

12.a. The agency shall implement a Medicaid prescription-drug-management system. The agency may contract with a vendor that has experience in operating prescription-drug-management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug-management system must be designed to improve the quality of care and prescribing practices based on best-practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the development and adoption of best-practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best-practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best-practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best-practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

(V) Track spending trends for prescription drugs and deviation from best-practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement disease-management programs in cooperation with physicians and pharmacists, along with a model quality-based medication component for individuals having chronic medical conditions.

13.~~12.~~ The agency is authorized to contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

14.~~13.~~ The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

15.~~14.~~ The agency may require prior authorization for the off-label use of Medicaid-covered prescribed drugs as specified in the General Appropriations Act. The agency may, but is not required to, preauthorize the use of a product for an indication not in the approved labeling. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the off-label use of a drug.

16.~~15.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused. The agency's conclusion and recommendations shall be reported to the Legislature by December 1, 2005.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

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

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

(41) The agency shall provide for the development of a demonstration project by establishment in Miami-Dade County of a long-term-care facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care

condominium and colocated with licensed facilities providing a continuum of care. The establishment of this project is not subject to the provisions of s. 408.036 or s. 408.039. The agency shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

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

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

(44) The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(h), whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31 of each year. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(45) Subject to the availability of funds, the agency shall mandate a recipient's participation in a provider lock-in program, when appropriate, if a recipient is found by the agency to have used Medicaid goods or services at a frequency or amount not medically necessary, limiting the receipt of goods or services to medically necessary providers after the 21-day appeal process has ended, for a period of not less than 1 year. The lock-in programs shall include, but are not limited to, pharmacies, medical doctors, and infusion clinics. The limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department. The agency shall seek any federal waivers necessary to implement this subsection. The agency shall adopt any rules necessary to comply with or administer this subsection.

(46) The agency shall seek a federal waiver for permission to terminate the eligibility of a Medicaid recipient who has been found to have committed fraud, through judicial or administrative determination, two times in a period of 5 years.

(47) The agency shall conduct a study of available electronic systems for the purpose of verifying the identity and eligibility of a Medicaid recipient. The agency shall recommend to the Legislature a plan to implement an electronic verification system for Medicaid recipients by January 31, 2005.

(48) A provider is not entitled to enrollment in the Medicaid provider network. The agency may implement a Medicaid fee-for-service provider network controls, including, but not limited to, competitive procurement and provider credentialing. If a credentialing process is used, the agency may limit its provider network based upon the following considerations: beneficiary access to care, provider availability, provider quality standards and quality assurance processes, cultural competency, demographic characteristics of beneficiaries, practice standards, service wait times, provider turnover, provider licensure and accreditation history, program integrity history, peer review, Medicaid policy and billing compliance records, clinical and medical record audit findings, and such other areas that are considered necessary by the agency to ensure the integrity of the program.

(49) The agency shall contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules.

(b) The agency shall reimburse each minority physician network as a fee-for-service provider, including the case management fee for primary care, or as a capitated rate provider for Medicaid services. Any savings shall be shared with the minority physician networks pursuant to the contract.

(c) For purposes of this subsection, the term “cost-effective” means that a network’s per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, must be no greater than the state’s costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(d) The agency may apply for any federal waivers needed to implement this subsection.

(50) To the extent permitted by federal law and as allowed under s. 409.906, the agency shall provide reimbursement for emergency mental

health care services for Medicaid recipients in crisis-stabilization facilities licensed under s. 394.875 as long as those services are less expensive than the same services provided in a hospital setting.

Section 2. Section 409.91211, Florida Statutes, is created to read:

409.91211 Medicaid managed care pilot program.—

(1) The agency is authorized to seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program pursuant to this section. Phase one of the demonstration shall be implemented in two geographic areas. One demonstration site shall include only Broward County. A second demonstration site shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational. This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under section 3 of this act, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature.

(2) The Legislature intends for the capitated managed care pilot program to:

(a) Provide recipients in Medicaid fee-for-service or the MediPass program a comprehensive and coordinated capitated managed care system for all health care services specified in ss. 409.905 and 409.906.

(b) Stabilize Medicaid expenditures under the pilot program compared to Medicaid expenditures in the pilot area for the 3 years before implementation of the pilot program, while ensuring:

1. Consumer education and choice.

2. Access to medically necessary services.

3. Coordination of preventative, acute, and long-term care.

4. Reductions in unnecessary service utilization.

(c) Provide an opportunity to evaluate the feasibility of statewide implementation of capitated managed care networks as a replacement for the current Medicaid fee-for-service and MediPass systems.

(3) The agency shall have the following powers, duties, and responsibilities with respect to the development of a pilot program:

(a) To develop and recommend a system to deliver all mandatory services specified in s. 409.905 and optional services specified in s. 409.906, as approved by the Centers for Medicare and Medicaid Services and the Legislature in the waiver pursuant to this section. Services to recipients under plan benefits shall include emergency services provided under s. 409.9128.

(b) To recommend Medicaid-eligibility categories, from those specified in ss. 409.903 and 409.904, which shall be included in the pilot program.

(c) To determine and recommend how to design the managed care pilot program in order to take maximum advantage of all available state and federal funds, including those obtained through intergovernmental transfers, the upper-payment-level funding systems, and the disproportionate share program.

(d) To determine and recommend actuarially sound, risk-adjusted capitation rates for Medicaid recipients in the pilot program which can be separated to cover comprehensive care, enhanced services, and catastrophic care.

(e) To determine and recommend policies and guidelines for phasing in financial risk for approved provider service networks over a 3-year period. These shall include an option to pay fee-for-service rates that may include a savings-settlement option for at least 2 years. This model may be converted to a risk-adjusted capitated rate in the third year of operation. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

(f) To determine and recommend provisions related to stop-loss requirements and the transfer of excess cost to catastrophic coverage that accommodates the risks associated with the development of the pilot program.

(g) To determine and recommend a process to be used by the Social Services Estimating Conference to determine and validate the rate of growth of the per-member costs of providing Medicaid services under the managed care pilot program.

(h) To determine and recommend program standards and credentialing requirements for capitated managed care networks to participate in the pilot program, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers. It is the intent of the Legislature that, to the extent possible, any pilot program authorized by the state under this section include any federally qualified health center, federally qualified rural health clinic, county health department, or other federally, state, or locally funded entity that serves the geographic areas within the boundaries of the pilot program that requests to participate. This paragraph does not relieve an entity that qualifies as a capitated managed care network under this section from any other licensure or regulatory requirements contained in state or federal law which would otherwise apply to the entity. The standards and credentialing requirements shall be based upon, but are not limited to:

1. Compliance with the accreditation requirements as provided in s. 641.512.

2. Compliance with early and periodic screening, diagnosis, and treatment screening requirements under federal law.

3. The percentage of voluntary disenrollments.

4. Immunization rates.

5. Standards of the National Committee for Quality Assurance and other approved accrediting bodies.

6. Recommendations of other authoritative bodies.

7. Specific requirements of the Medicaid program, or standards designed to specifically meet the unique needs of Medicaid recipients.

8. Compliance with the health quality improvement system as established by the agency, which incorporates standards and guidelines developed by the Centers for Medicare and Medicaid Services as part of the quality assurance reform initiative.

9. The network's infrastructure capacity to manage financial transactions, recordkeeping, data collection, and other administrative functions.

10. The network's ability to submit any financial, programmatic, or patient-encounter data or other information required by the agency to determine the actual services provided and the cost of administering the plan.

(i) To develop and recommend a mechanism for providing information to Medicaid recipients for the purpose of selecting a capitated managed care plan. For each plan available to a recipient, the agency, at a minimum shall ensure that the recipient is provided with:

1. A list and description of the benefits provided.

2. Information about cost sharing.

3. Plan performance data, if available.

4. An explanation of benefit limitations.

5. Contact information, including identification of providers participating in the network, geographic locations, and transportation limitations.

6. Any other information the agency determines would facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs.

(j) To develop and recommend a system to ensure that there is a record of recipient acknowledgment that choice counseling has been provided.

(k) To develop and recommend a choice counseling system to ensure that the choice counseling process and related material are designed to provide

counseling through face-to-face interaction, by telephone, and in writing and through other forms of relevant media. Materials shall be written at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also use language lines and other services for impaired recipients, such as TTD/TTY.

(l) To develop and recommend a system that prohibits capitated managed care plans, their representatives, and providers employed by or contracted with the capitated managed care plans from recruiting persons eligible for or enrolled in Medicaid, from providing inducements to Medicaid recipients to select a particular capitated managed care plan, and from prejudicing Medicaid recipients against other capitated managed care plans. The system shall require the entity performing choice counseling to determine if the recipient has made a choice of a plan or has opted out because of duress, threats, payment to the recipient, or incentives promised to the recipient by a third party. If the choice counseling entity determines that the decision to choose a plan was unlawfully influenced or a plan violated any of the provisions of s. 409.912(21), the choice counseling entity shall immediately report the violation to the agency's program integrity section for investigation. Verification of choice counseling by the recipient shall include a stipulation that the recipient acknowledges the provisions of this subsection.

(m) To develop and recommend a choice counseling system that promotes health literacy and provides information aimed to reduce minority health disparities through outreach activities for Medicaid recipients.

(n) To develop and recommend a system for the agency to contract with entities to perform choice counseling. The agency may establish standards and performance contracts, including standards requiring the contractor to hire choice counselors who are representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.

(o) To determine and recommend descriptions of the eligibility assignment processes which will be used to facilitate client choice while ensuring pilot programs of adequate enrollment levels. These processes shall ensure that pilot sites have sufficient levels of enrollment to conduct a valid test of the managed care pilot program within a 2-year timeframe.

(p) To develop and recommend a system to monitor the provision of health care services in the pilot program, including utilization and quality of health care services for the purpose of ensuring access to medically necessary services. This system shall include an encounter data-information system that collects and reports utilization information. The system shall include a method for verifying data integrity within the database and within the provider's medical records.

(q) To recommend a grievance-resolution process for Medicaid recipients enrolled in a capitated managed care network under the pilot program modeled after the subscriber assistance panel, as created in s. 408.7056. This process shall include a mechanism for an expedited review of no greater

than 24 hours after notification of a grievance if the life of a Medicaid recipient is in imminent and emergent jeopardy.

(r) To recommend a grievance-resolution process for health care providers employed by or contracted with a capitated managed care network under the pilot program in order to settle disputes among the provider and the managed care network or the provider and the agency.

(s) To develop and recommend criteria to designate health care providers as eligible to participate in the pilot program. The agency and capitated managed care networks must follow national guidelines for selecting health care providers, whenever available. These criteria must include at a minimum those criteria specified in s. 409.907.

(t) To develop and recommend health care provider agreements for participation in the pilot program.

(u) To require that all health care providers under contract with the pilot program be duly licensed in the state, if such licensure is available, and meet other criteria as may be established by the agency. These criteria shall include at a minimum those criteria specified in s. 409.907.

(v) To develop and recommend agreements with other state or local governmental programs or institutions for the coordination of health care to eligible individuals receiving services from such programs or institutions.

(w) To develop and recommend a system to oversee the activities of pilot program participants, health care providers, capitated managed care networks, and their representatives in order to prevent fraud or abuse, overutilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of participants and to recover overpayments as appropriate. For the purposes of this paragraph, the terms "abuse" and "fraud" have the meanings as provided in s. 409.913. The agency must refer incidents of suspected fraud, abuse, overutilization and duplicative utilization, and underutilization or inappropriate denial of services to the appropriate regulatory agency.

(x) To develop and provide actuarial and benefit design analyses that indicate the effect on capitation rates and benefits offered in the pilot program over a prospective 5-year period based on the following assumptions:

1. Growth in capitation rates which is limited to the estimated growth rate in general revenue.

2. Growth in capitation rates which is limited to the average growth rate over the last 3 years in per-recipient Medicaid expenditures.

3. Growth in capitation rates which is limited to the growth rate of aggregate Medicaid expenditures between the 2003-2004 fiscal year and the 2004-2005 fiscal year.

(y) To develop a mechanism to require capitated managed care plans to reimburse qualified emergency service providers, including, but not limited

to, ambulance services, in accordance with ss. 409.908 and 409.9128. The pilot program must include a provision for continuing fee-for-service payments for emergency services, including but not limited to, individuals who access ambulance services or emergency departments and who are subsequently determined to be eligible for Medicaid services.

(z) To develop a system whereby school districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good-faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 must be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good-faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's capitated managed care network provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(aa) To develop and recommend a mechanism whereby Medicaid recipients who are already enrolled in a managed care plan or the MediPass program in the pilot areas shall be offered the opportunity to change to capitated managed care plans on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of capitated managed care plans. Those Medicaid recipients who do not make a choice shall be assigned to a capitated managed care plan in accordance with paragraph (4)(a). To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a capitated managed care plan, the agency shall determine whether the SSI recipient has an ongoing relationship with a provider or capitated managed care plan, and if so, the agency shall assign the SSI recipient to that provider or capitated managed care plan where feasible. Those SSI recipients who do not have such a provider relationship shall be assigned to a capitated managed care plan provider in accordance with paragraph (4)(a).

(bb) To develop and recommend a service delivery alternative for children having chronic medical conditions which establishes a medical home project to provide primary care services to this population. The project shall provide community-based primary care services that are integrated with other subspecialties to meet the medical, developmental, and emotional needs for children and their families. This project shall include an evaluation component to determine impacts on hospitalizations, length of stays,

emergency room visits, costs, and access to care, including specialty care and patient, and family satisfaction.

(cc) To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to persons with developmental disabilities sufficient to meet the medical, developmental, and emotional needs of these persons.

(dd) To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to Medicaid-eligible children in foster care. These services must be coordinated with community-based care providers as specified in s. 409.1675, where available, and be sufficient to meet the medical, developmental, and emotional needs of these children.

(4)(a) A Medicaid recipient in the pilot area who is not currently enrolled in a capitated managed care plan upon implementation is not eligible for services as specified in ss. 409.905 and 409.906, for the amount of time that the recipient does not enroll in a capitated managed care network. If a Medicaid recipient has not enrolled in a capitated managed care plan within 30 days after eligibility, the agency shall assign the Medicaid recipient to a capitated managed care plan based on the assessed needs of the recipient as determined by the agency. When making assignments, the agency shall take into account the following criteria:

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

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

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

4. The capitated managed care network's primary care providers are geographically accessible to the recipient's residence.

(b) When more than one capitated managed care network provider meets the criteria specified in paragraph (3)(h), the agency shall make recipient assignments consecutively by family unit.

(c) The agency may not engage in practices that are designed to favor one capitated managed care plan over another or that are designed to influence Medicaid recipients to enroll in a particular capitated managed care network in order to strengthen its particular fiscal viability.

(d) After a recipient has made a selection or has been enrolled in a capitated managed care network, the recipient shall have 90 days in which to voluntarily disenroll and select another capitated managed care network. After 90 days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary

specialty services, an unreasonable delay or denial of service, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. The agency may require a recipient to use the capitated managed care network's grievance process as specified in paragraph (3)(g) prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when used, must be completed in time to permit the recipient to disenroll no later than the first day of the second month after the month the disenrollment request was made. If the capitated managed care network, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(e) The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a capitated managed care network for 12 months after an open enrollment period. After 12 months of enrollment, a recipient may select another capitated managed care network. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the capitated managed care network during the 12-month period.

(f) The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to allow recipients to purchase health care coverage through an employer-sponsored health insurance plan instead of through a Medicaid-certified plan. This provision shall be known as the opt-out option.

1. A recipient who chooses the Medicaid opt-out option shall have an opportunity for a specified period of time, as authorized under a waiver granted by the Centers for Medicare and Medicaid Services, to select and enroll in a Medicaid-certified plan. If the recipient remains in the employer-sponsored plan after the specified period, the recipient shall remain in the opt-out program for at least 1 year or until the recipient no longer has access to employer-sponsored coverage, until the employer's open enrollment period for a person who opts out in order to participate in employer-sponsored coverage, or until the person is no longer eligible for Medicaid, whichever time period is shorter.

2. Notwithstanding any other provision of this section, coverage, cost sharing, and any other component of employer-sponsored health insurance shall be governed by applicable state and federal laws.

(5) This section does not authorize the agency to implement any provision of s. 1115 of the Social Security Act experimental, pilot, or demonstration project waiver to reform the state Medicaid program in any part of the

state other than the two geographic areas specified in this section unless approved by the Legislature.

(6) The agency shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to implement the managed care pilot project as defined in this section. The agency shall post all waiver applications under this section on its Internet website 30 days before submitting the applications to the United States Centers for Medicare and Medicaid Services. All waiver applications shall be provided for review and comment to the appropriate committees of the Senate and House of Representatives for at least 10 working days prior to submission. All waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section must be approved by the Legislature. Federally approved waivers must be submitted to the President of the Senate and the Speaker of the House of Representatives for referral to the appropriate legislative committees. The appropriate committees shall recommend whether to approve the implementation of any waivers to the Legislature as a whole. The agency shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the pilot program under this section on the total Medicaid budget for the 2006-2007 through 2009-2010 state fiscal years. This implementation plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives at the same time any waivers are submitted for consideration by the Legislature.

(7) Upon review and approval of the applications for waivers of applicable federal laws and regulations to implement the managed care pilot program by the Legislature, the agency may initiate adoption of rules pursuant to ss. 120.536(1) and 120.54 to implement and administer the managed care pilot program as provided in this section.

Section 3. The Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, shall comprehensively evaluate the two managed care pilot programs created under section 409.91211, Florida Statutes. The evaluation shall begin with the implementation of the managed care model in the pilot areas and continue for 24 months after the two pilot programs have enrolled Medicaid recipients and started providing health care services. The evaluation must include assessments of cost savings; consumer education, choice, and access to services; coordination of care; and quality of care by each eligibility category and managed care plan in each pilot site. The evaluation must describe administrative or legal barriers to the implementation and operation of each pilot program and include recommendations regarding statewide expansion of the managed care pilot programs. The office shall submit an evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than June 30, 2008.

Section 4. Section 409.9062, Florida Statutes, is amended to read:

409.9062 Lung transplant services for Medicaid recipients.—Subject to the availability of funds and subject to any limitations or directions provided for in the General Appropriations Act or chapter 216, the Agency for Health

Care Administration Medicaid program shall pay for medically necessary lung transplant services for Medicaid recipients. These payments must be used to reimburse approved lung transplant facilities a global fee for providing lung transplant services to Medicaid recipients.

Section 5. The sums of $401,098 from the General Revenue Fund and $593,058 from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing section 4 during the 2005-2006 fiscal year.

Section 6. Paragraphs (a) and (j) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)(a) The agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid recipients who are: in an institution; enrolled in the Medicaid medically needy program; or eligible for both Medicaid and Medicare. Upon enrollment, individuals will be able to change their managed care option during the 90-day opt out period required by federal Medicaid regulations. The agency is authorized to seek the necessary Medicaid state plan amendment to implement this policy. However, to the extent permitted by federal law, the agency may enroll in a managed care plan or MediPass a Medicaid recipient who is exempt from mandatory managed care enrollment, provided that:

1. The recipient's decision to enroll in a managed care plan or MediPass is voluntary;

2. If the recipient chooses to enroll in a managed care plan, the agency has determined that the managed care plan provides specific programs and services which address the special health needs of the recipient; and

3. The agency receives any necessary waivers from the federal Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~.

The agency shall develop rules to establish policies by which exceptions to the mandatory managed care enrollment requirement may be made on a case-by-case basis. The rules shall include the specific criteria to be applied when making a determination as to whether to exempt a recipient from mandatory enrollment in a managed care plan or MediPass. School districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives

Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(j) The agency shall apply for a federal waiver from the Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~ to lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an open enrollment period. After 12 months' enrollment, a recipient may select another managed care plan or MediPass provider. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the managed care plan or MediPass program during the 12-month period.

Section 7. Subsection (2) of section 409.913, Florida Statutes, is amended, and subsection (36) is added to that section, to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis.

(36) The agency shall provide to each Medicaid recipient or his or her representative an explanation of benefits in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Children and Family Services. The explanation of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation.

Section 8. The Agency for Health Care Administration shall submit to the Legislature by December 15, 2005, a report on the legal and administrative barriers to enforcing section 409.9081, Florida Statutes. The report must describe how many services require copayments, which providers collect copayments, and the total amount of copayments collected from recipients for all services required under section 409.9081, Florida Statutes, by provider type for the 2001-2002 through 2004-2005 fiscal years. The agency shall recommend a mechanism to enforce the requirement for Medicaid recipients to make copayments which does not shift the copayment amount to the provider. The agency shall also identify the federal or state laws or regulations that permit Medicaid recipients to declare impoverishment in order to avoid paying the copayment and extent to which these statements of impoverishment are verified. If claims of impoverishment are not currently verified, the agency shall recommend a system for such verification. The report must also identify any other cost-sharing measures that could be imposed on Medicaid recipients.

Section 9. The Agency for Health Care Administration shall submit to the Legislature by January 15, 2006, recommendations to ensure that Medicaid is the payer of last resort as required by section 409.910, Florida Statutes. The report must identify the public and private entities that are liable for primary payment of health care services and recommend methods to improve enforcement of third-party liability responsibility and repayment of benefits to the state Medicaid program. The report must estimate the potential recoveries that may be achieved through third-party liability efforts if administrative and legal barriers are removed. The report must recommend whether modifications to the agency's contingency-fee contract for third-party liability could enhance third-party liability for benefits provided to Medicaid recipients.

Section 10. By January 15, 2006, the Office of Program Policy Analysis and Government Accountability shall submit to the Legislature a study of the long-term care community diversion pilot project authorized under sections 430.701-430.709, Florida Statutes. The study may be conducted by

staff of the Office of Program Policy Analysis and Government Accountability or by a consultant obtained through a competitive bid pursuant to the provisions of chapter 287, Florida Statutes. The study must use a statistically-valid methodology to assess the percent of persons served in the project over a 2-year period who would have required Medicaid nursing home services without the diversion services, which services are most frequently used, and which services are least frequently used. The study must determine whether the project is cost-effective or is an expansion of the Medicaid program because a preponderance of the project enrollees would not have required Medicaid nursing home services within a 2-year period regardless of the availability of the project or that the enrollees could have been safely served through another Medicaid program at a lower cost to the state.

Section 11. The Agency for Health Care Administration shall identify how many individuals in the long-term care diversion programs who receive care at home have a patient-responsibility payment associated with their participation in the diversion program. If no system is available to assess this information, the agency shall determine the cost of creating a system to identify and collect these payments and whether the cost of developing a system for this purpose is offset by the amount of patient-responsibility payments which could be collected with the system. The agency shall report this information to the Legislature by December 1, 2005.

Section 12. The Office of Program Policy Analysis and Government Accountability shall conduct a study of state programs that allow non-Medicaid eligible persons under a certain income level to buy into the Medicaid program as if it was private insurance. The study shall examine Medicaid buy-in programs in other states to determine if there are any models that can be implemented in Florida which would provide access to uninsured Floridians and what effect this program would have on Medicaid expenditures based on the experience of similar states. The study must also examine whether the Medically Needy program could be redesigned to be a Medicaid buy-in program. The study must be submitted to the Legislature by January 1, 2006.

Section 13. The Office of Program Policy Analysis and Government Accountability, in consultation with the Office of Attorney General, Medicaid Fraud Control Unit and the Auditor General, shall conduct a study to examine issues related to the amount of state and federal dollars lost due to fraud and abuse in the Medicaid prescription drug program. The study shall focus on examining whether pharmaceutical manufacturers and their affiliates and wholesale pharmaceutical manufacturers and their affiliates that participate in the Medicaid program in this state, with respect to rebates for prescription drugs, are inflating the average wholesale price that is used in determining how much the state pays for prescription drugs for Medicaid recipients. The study shall also focus on examining whether the manufacturers and their affiliates are committing other deceptive pricing practices with regard to federal and state rebates for prescription drugs in the Medicaid program in this state. The study, including findings and recommendations, shall be submitted to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate,

and the Minority Leader of the House of Representatives by January 1, 2006.

Section 14. The sums of $7,129,241 in recurring General Revenue Funds, $9,076,875 in nonrecurring General Revenue Funds, $8,608,242 in recurring funds from the Administrative Trust Fund, and $9,076,874 in nonrecurring funds from the Administrative Trust Fund are appropriated and 11 full time equivalent positions are authorized for the purpose of implementing this act.

Section 15. The amendments made to section 393.0661, Florida Statutes, by the Conference Committee Report on Committee Substitute for Committee Substitute for Senate Bill 404 are repealed.

Section 16. The amendments made to section 409.907, Florida Statutes, by the Conference Committee Report on Committee Substitute for Committee Substitute for Senate Bill 404 are repealed.

Section 17. The amendments made to the introductory provision only of section 409.908, Florida Statutes, by the Conference Committee Report on Committee Substitute for Committee Substitute for Senate Bill 404 are repealed.

Section 18. Section 409.9082, Florida Statutes, as created by the Conference Committee Report on Committee Substitute for Committee Substitute for Senate Bill 404, is repealed.

Section 19. Section 23 of the Conference Committee Report on Committee Substitute for Committee Substitute for Senate Bill 404 is repealed.

Section 20. Subsection (2) of section 409.9124, Florida Statutes, as amended by section 18 of the Conference Committee Report on Committee Substitute for Committee Substitute for Senate Bill 404 is amended, and subsection (6) is added to that section, to read:

409.9124 Managed care reimbursement.—

(2) Each year prior to establishing new managed care rates, the agency shall review all prior year adjustments for changes in trend, and shall reduce or eliminate those adjustments which are not reasonable and which reflect policies or programs which are not in effect. In addition, the agency shall apply only those policy reductions applicable to the fiscal year for which the rates are being set, which can be accurately estimated and verified by an independent actuary, and which have been implemented prior to or will be implemented during the fiscal year. The agency shall pay rates at per-member, per-month averages that ~~equal, but~~ do not exceed~~,~~ the amounts allowed for in the General Appropriations Act applicable to the fiscal year for which the rates will be in effect.

(6) For the 2005-2006 fiscal year only, the agency shall make an additional adjustment in calculating the capitation payments to prepaid health plans, excluding prepaid mental health plans. This adjustment must result in an increase of 2.8 percent in the average per-member, per-month rate

paid to prepaid health plans, excluding prepaid mental health plans, which are funded from Specific Appropriations 225 and 226 in the 2005-2006 General Appropriations Act.

Section 21. The Senate Select Committee on Medicaid Reform shall study how provider rates are established and modified, how provider agreements and administrative rulemaking effect those rates, the discretion allowed by federal law for the setting of rates by the state, and the impact of litigation on provider rates. The committee shall issue a report containing recommendations by March 1, 2006, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 22. This act shall take effect July 1, 2005.

Approved by the Governor June 3, 2005.

Filed in Office Secretary of State June 3, 2005.