By the Fiscal Responsibility Council and Representative Maygarden

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 409.8132, F.S.; deleting the requirement to provide choice counseling to eligible applicants under the Medikids program component; amending s. 409.815, F.S.; correcting a cross reference; amending s. 409.903, F.S.; revising Medicaid eligibility requirements for pregnant women and children under age 1; amending s. 409.904, F.S.; revising Medicaid eligibility requirements for certain elderly or disabled persons; revising Medicaid eligibility requirements of postpartum women for family planning services; authorizing payment for health insurance premiums of Medicaid-eligible individuals under certain circumstances; amending s. 409.905, F.S.; updating and revising provisions relating to hospital inpatient behavioral health services provided pursuant to a federally approved waiver; expanding provision of such services statewide; amending s. 409.906, F.S.; deleting adult denture services as optional Medicaid services and restricting authorized hearing and visual services to children; providing additional requirements for authorized intermediate care services; adding assistive care services as an optional Medicaid service for certain recipients; amending s. 409.9065, F.S.; correcting a cross reference; amending s.

409.908, F.S.; providing for reimbursement of hospital inpatient and outpatient services at certain rates; permitting reimbursement for certain Medicaid services based on competitive bidding; deleting redundant provisions; prohibiting increases in reimbursement rates to nursing homes associated with changes in ownership; precluding premium adjustments to managed care organizations under certain circumstances; revising provisions relating to physician reimbursement and the reimbursement fee schedule; deleting certain preferential Medicaid payments for dually eligible recipients; authorizing competitive procurement of transportation services or the securing through waivers of federal financing of transportation services at certain rates; correcting a cross reference; authorizing public schools affiliated with Florida universities to separately enroll in the Medicaid certified school match program and certify local expenditures; amending s. 409.911, F.S.; updating data requirements and share rates for disproportionate share distributions; amending s. 409.91195, F.S.; revising provisions relating to the membership of the Medicaid Pharmaceutical and Therapeutics Committee; providing for development and distribution of a restricted drug formulary for Medicaid providers; amending s. 409.9116, F.S.; modifying the formula for disproportionate

share/financial assistance distributions to rural hospitals; amending s. 409.912, F.S.; authorizing continued reimbursement of substance abuse treatment services on a fee-for-service basis under certain conditions; expanding Medicaid managed care behavioral health services statewide; deleting requirement for choice counseling; deleting authorization to test new marketing initiatives relating to managed care options; deleting a restriction on adjustment of capitation rates; permitting competitive bidding for certain services; modifying reimbursement to pharmacies; permitting use of a restricted drug formulary, authorizing exemptions therefrom, and authorizing negotiation of supplemental rebates from manufacturers pursuant thereto; requiring prescriptions for Medicaid recipients to be on certain standardized forms; amending s. 409.915, F.S.; increasing county contributions to Medicaid for inpatient hospitalization; exempting counties from contributing toward the cost of inpatient services provided by certain hospitals and for special Medicaid payments under certain conditions; repealing s. 636.0145, F.S., relating to requirement for licensure of certain entities contracting with Medicaid to provide mental health care services in certain counties pursuant to federal waiver, to conform to changes made in this act;

providing a finding of important state interest; providing an effective date.

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

Section 1. Subsection (7) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.--

(7) ENROLLMENT.--Enrollment in the Medikids program component may only occur during periodic open enrollment periods as specified by the agency. An applicant may apply for enrollment in the Medikids program component and proceed through the eligibility determination process at any time throughout the year. However, enrollment in Medikids shall not begin until the next open enrollment period; and a child may not receive services under the Medikids program until the child is enrolled in a managed care plan or MediPass. ~~In addition,~~Once determined eligible, an applicant may choose ~~receive choice counseling and select~~ a managed care plan or MediPass. The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's voluntary choice period ends. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients and only if the federal Health Care Financing Administration determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act.

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

409.815 Health benefits coverage; limitations.--

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

(q) Dental services.--Subject to a specific appropriation for this benefit, covered services include those dental services provided to children by the Florida Medicaid program under s. 409.906(5)~~(6)~~.

Section 3. Subsection (5) of section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.--The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(5) A pregnant woman for the duration of her pregnancy and for the postpartum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level~~, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level~~. Such a person is not subject to an assets test. Further, a pregnant woman who

applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

Section 4. Subsections (1) and (5) of section 409.904, Florida Statutes, are amended, and subsection (9) is added to said section, to read:

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid-eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) A person who is age 65 or older or is determined to be disabled, whose income is at or below 85 ~~100~~ percent of federal poverty level, and whose assets do not exceed established limitations.

(5) Subject to specific federal authorization, a postpartum woman living in a family that has an income that is at or below 150 ~~185~~ percent of the most current federal poverty level is eligible for family planning services as specified in s. 409.905(3) for a period of up to 24 months following a pregnancy for which Medicaid paid for pregnancy-related services.

(9) A Medicaid-eligible individual for the individual's health insurance premiums, if the agency determines that such payments are cost-effective.

Section 5. Subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

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

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs;

adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase.

(b) A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Medicaid program except as provided under ~~in~~ federal law or pursuant to a federally approved waiver~~. However, the department shall apply for a waiver, within 9 months after June 5, 1991,~~designed to provide behavioral health ~~hospitalization~~ services ~~for mental health reasons~~ to children and adults in the most cost-effective and lowest cost setting possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The behavioral health waiver proposal shall propose no additional aggregate cost to the state or Federal Government~~, and shall be conducted in Hillsborough County, Highlands County, Hardee County, Manatee County, and Polk County~~. Implementation of the behavioral health waiver proposal shall not be the basis for adjusting a hospital's Medicaid inpatient or outpatient rate.The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. ~~When developing~~ The waiver proposal~~, the department~~ shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to ensure the earliest discharge possible, and the

comprehensiveness of the mental health and other health care services offered by participating providers.

~~(c) Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:~~

~~1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995; or~~

~~2. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year.~~

~~No later than November 1, 2000, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Budget Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the 2001-2002 General Appropriations Act to support the increase in cost as estimated by the agency. This paragraph is repealed on July 1, 2001.~~

Section 6. Section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on

the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

~~(1) ADULT DENTURE SERVICES.--The agency may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is age 21 or older.~~

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

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

395, by or under the direction of a licensed physician or dentist.

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

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

(5)~~(6)~~ CHILDREN'S DENTAL SERVICES.--The agency may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual.

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

(7)~~(8)~~ COMMUNITY MENTAL HEALTH SERVICES.--The agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider licensed by the agency and under contract with the agency or the Department of Children and Family Services to provide such services. Those services which are psychiatric in nature shall be rendered or recommended by a psychiatrist, and those services which are medical in nature shall be rendered or recommended by a physician or psychiatrist. The agency must develop a provider enrollment process for community mental health providers which bases provider enrollment on an assessment of service need. The provider enrollment process shall be designed to control costs, prevent fraud and abuse, consider provider expertise and capacity, and assess provider success in managing utilization of care and measuring treatment outcomes. Providers will be selected through a competitive procurement or selective contracting process. In addition to other community mental health providers, the agency shall consider for enrollment mental health programs licensed under chapter 395 and group practices licensed under chapter 458, chapter 459, chapter 490, or chapter 491. The agency is also authorized to continue operation of its behavioral health utilization management program and may develop new services if these actions are necessary to ensure savings from the implementation of the utilization management system. The agency shall coordinate the implementation of this enrollment process with the Department of Children and Family Services

and the Department of Juvenile Justice. The agency is authorized to utilize diagnostic criteria in setting reimbursement rates, to preauthorize certain high-cost or highly utilized services, to limit or eliminate coverage for certain services, or to make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(8)~~(9)~~ DIALYSIS FACILITY SERVICES.--Subject to specific appropriations being provided for this purpose, the agency may pay a dialysis facility that is approved as a dialysis facility in accordance with Title XVIII of the Social Security Act, for dialysis services that are provided to a Medicaid recipient under the direction of a physician licensed to practice medicine or osteopathic medicine in this state, including dialysis services provided in the recipient's home by a hospital-based or freestanding dialysis facility.

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

(10)~~(11)~~ HEALTHY START SERVICES.--The agency may pay for a continuum of risk-appropriate medical and psychosocial services for the Healthy Start program in accordance with a federal waiver. The agency may not implement the federal waiver unless the waiver permits the state to limit enrollment or the amount, duration, and scope of services to ensure that expenditures will not exceed funds appropriated by the Legislature or available from local sources. If the Health Care Financing Administration does not approve a federal waiver for Healthy Start services, the agency, in consultation with the Department of Health and the Florida Association of

Healthy Start Coalitions, is authorized to establish a Medicaid certified-match program for Healthy Start services. Participation in the Healthy Start certified-match program shall be voluntary, and reimbursement shall be limited to the federal Medicaid share to Medicaid-enrolled Healthy Start coalitions for services provided to Medicaid recipients. The agency shall take no action to implement a certified-match program without ensuring that the amendment and review requirements of ss. 216.177 and 216.181 have been met.

(11)~~(12)~~ HEARING SERVICES.--Except for individuals 21 years of age or older,the agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(12)~~(13)~~ HOME AND COMMUNITY-BASED SERVICES.--The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program.

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

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

for a recipient who needs such care because of a developmental disability.

(15)~~(16)~~ INTERMEDIATE CARE SERVICES.--The agency may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part II of chapter 400, if the services are ordered by and provided under the direction of a physician, meet nursing home level of care criteria as determined by the Comprehensive Assessment and Review Long-Term Care (CARE) Program of the Department of Elderly Affairs, and do not meet the definition of "general care" as used in the Medicaid budget estimating process.

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

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

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

(19)~~(20)~~ PRESCRIBED DRUG SERVICES.--The agency may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts

authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

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

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

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

(23)~~(24)~~ CHILD-WELFARE-TARGETED CASE MANAGEMENT.--The Agency for Health Care Administration, in consultation with the Department of Children and Family Services, may establish a targeted case-management pilot project in those counties identified by the Department of Children and Family Services and for the community-based child welfare project in Sarasota and Manatee counties, as authorized under s. 409.1671. These projects shall be established for the purpose of determining the impact of targeted case management on the child welfare program and the earnings from the child welfare program. Results of the pilot projects shall be reported to the Child Welfare Estimating Conference and the Social Services Estimating Conference established under s. 216.136. The number

of projects may not be increased until requested by the Department of Children and Family Services, recommended by the Child Welfare Estimating Conference and the Social Services Estimating Conference, and approved by the Legislature. The covered group of individuals who are eligible to receive targeted case management include children who are eligible for Medicaid; who are between the ages of birth through 21; and who are under protective supervision or postplacement supervision, under foster-care supervision, or in shelter care or foster care. The number of individuals who are eligible to receive targeted case management shall be limited to the number for whom the Department of Children and Family Services has available matching funds to cover the costs. The general revenue funds required to match the funds for services provided by the community-based child welfare projects are limited to funds available for services described under s. 409.1671. The Department of Children and Family Services may transfer the general revenue matching funds as billed by the Agency for Health Care Administration.

(24) ASSISTIVE CARE SERVICES.--The agency may pay for assistive care services provided to recipients with functional or cognitive impairments residing in assisted living facilities, adult family-care homes, or residential treatment facilities with 16 or fewer beds. These services may include health support, assistance with the activities of daily living and the instrumental acts of daily living, assistance with medication administration, and arrangements for health care.

Section 7. Subsection (3) of section 409.9065, Florida Statutes, is amended to read:

409.9065 Pharmaceutical expense assistance.--

(3) BENEFITS.--Medications covered under the pharmaceutical expense assistance program are those covered under the Medicaid program in s. 409.906(19)~~(20)~~. Monthly benefit payments shall be limited to $80 per program participant. Participants are required to make a 10-percent coinsurance payment for each prescription purchased through this program.

Section 8. Section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under ~~part I of~~ chapter 395 must be made prospectively or on the basis of negotiation or competitive bidding. The agency shall reimburse for hospital inpatient and outpatient services under this subsection at rates no greater than 95 percent of the reimbursement rates in effect for the 2000-2001 state fiscal year.

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5), except for:

1. The raising of rate reimbursement caps, excluding rural hospitals.

2. Recognition of the costs of graduate medical education.

3. Other methodologies recognized in the General Appropriations Act.

During the years funds are transferred from the Board of Regents, any reimbursement supported by such funds shall be subject to certification by the Board of Regents that the hospital has complied with s. 381.0403. The agency is authorized to receive funds from state entities, including, but not limited to, the Board of Regents, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received from state entities or local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner. ~~Notwithstanding this section and s. 409.915, counties are exempt from contributing toward the cost of the special exception reimbursement for hospitals serving a~~

~~disproportionate share of low-income persons and providing graduate medical education.~~

(b) Reimbursement for hospital outpatient care is limited to $1,500 per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

2. Renal dialysis services.

3. Other exceptions made by the agency.

The agency is authorized to receive funds from state entities, including, but not limited to, the Board of Regents, local governments, and other local political subdivisions, for the purpose of making payments, including federal matching funds, through the Medicaid outpatient reimbursement methodologies. Funds received from state entities and local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(c) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and the methodologies described in ss. 409.911, 409.9112, and 409.9113.

(d) The agency is authorized to limit inflationary increases for outpatient hospital services as directed by the General Appropriations Act.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 ~~and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under chapter 393~~ must be made prospectively or on the basis of competitive bidding.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under ~~part I of~~ chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under ~~part I of~~ chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement must be determined by averaging the nursing home payments, in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under ~~part I of~~ chapter 395 for the temporary provision of skilled nursing

services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. The agency shall not provide for any increases in reimbursement rates to nursing homes associated with changes in ownership.Under the plan, interim rate adjustments shall not be granted to reflect increases in the cost of general or professional liability insurance for nursing homes unless the following criteria are met: have at least a 65 percent Medicaid utilization in the most recent cost report submitted to the agency, and the increase in general or professional liability costs to the facility for the most recent policy period affects the total Medicaid per diem by at least 5 percent. This rate adjustment shall not result in the per diem exceeding the class ceiling. This provision shall apply only to fiscal year 2000-2001 and shall be implemented to the extent existing appropriations are available. The agency shall report to the Governor, the Speaker of the House of Representatives, and the President of

the Senate by December 31, 2000, on the cost of liability insurance for Florida nursing homes for fiscal years 1999 and 2000 and the extent to which these costs are not being compensated by the Medicaid program. Medicaid-participating nursing homes shall be required to report to the agency information necessary to compile this report. Effective no earlier than the rate-setting period beginning April 1, 1999, the agency shall establish a case-mix reimbursement methodology for the rate of payment for long-term care services for nursing home residents. The agency shall compute a per diem rate for Medicaid residents, adjusted for case mix, which is based on a resident classification system that accounts for the relative resource utilization by different types of residents and which is based on level-of-care data and other appropriate data. The case-mix methodology developed by the agency shall take into account the medical, behavioral, and cognitive deficits of residents. In developing the reimbursement methodology, the agency shall evaluate and modify other aspects of the reimbursement plan as necessary to improve the overall effectiveness of the plan with respect to the costs of patient care, operating costs, and property costs. In the event adequate data are not available, the agency is authorized to adjust the patient's care component or the per diem rate to more adequately cover the cost of services provided in the patient's care component. The agency shall work with the Department of Elderly Affairs, the Florida Health Care Association, and the Florida Association of Homes for the Aging in developing the methodology. It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging

diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(3) Subject to any limitations or directions provided for in the General Appropriations Act, the following Medicaid services and goods may be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less, with the exception of those services or goods for which the agency makes payment using a methodology based on capitation rates, average costs, ~~or~~ negotiated fees, or competitive bidding.

(a) Advanced registered nurse practitioner services.

(b) Birth center services.

(c) Chiropractic services.

(d) Community mental health services.

(e) Dental services, including oral and maxillofacial surgery.

(f) Durable medical equipment.

(g) Hearing services for Medicaid recipients under age 21.

(h) Occupational therapy for Medicaid recipients under age 21.

(i) Optometric services.

(j) Orthodontic services.

(k) Personal care for Medicaid recipients under age 21.

(l) Physical therapy for Medicaid recipients under age 21.

(m) Physician assistant services.

(n) Podiatric services.

(o) Portable X-ray services.

(p) Private-duty nursing for Medicaid recipients under age 21.

(q) Registered nurse first assistant services.

(r) Respiratory therapy for Medicaid recipients under age 21.

(s) Speech therapy for Medicaid recipients under age 21.

(t) Visual services <u>for Medicaid recipients under age 21</u>.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and, beginning September

1, 1995, shall include age-band differentials in such calculations. Effective July 1, 2001, the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals from reimbursement ceilings and the cost of special Medicaid payments shall not be included in premiums paid to health maintenance organizations or prepaid health care plans.

(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.

(6) A provider of early and periodic screening, diagnosis, and treatment services to Medicaid recipients who are children under age 21 shall be reimbursed using an all-inclusive rate stipulated in a fee schedule established by the agency. A provider of the visual, dental, and hearing components of such services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(7) A provider of family planning services shall be reimbursed the lesser of the amount billed by the provider or an all-inclusive amount per type of visit for physicians and advanced registered nurse practitioners, as established by the agency in a fee schedule.

(8) A provider of home-based or community-based services rendered pursuant to a federally approved waiver shall be reimbursed based on an established or negotiated rate for each service. These rates shall be established according to an analysis of the expenditure history and prospective budget developed by each contract provider participating in the waiver program, or under any other methodology adopted by the agency and approved by the Federal Government in

accordance with the waiver. Effective July 1, 1996, privately owned and operated community-based residential facilities which meet agency requirements and which formerly received Medicaid reimbursement for the optional intermediate care facility for the mentally retarded service may participate in the developmental services waiver as part of a home-and-community-based continuum of care for Medicaid recipients who receive waiver services.

(9) A provider of home health care services or of medical supplies and appliances shall be reimbursed on the basis of competitive bidding or for the lesser of the amount billed by the provider or the agency's established maximum allowable amount, except that, in the case of the rental of durable medical equipment, the total rental payments may not exceed the purchase price of the equipment over its expected useful life or the agency's established maximum allowable amount, whichever amount is less.

(10) A hospice shall be reimbursed through a prospective system for each Medicaid hospice patient at Medicaid rates using the methodology established for hospice reimbursement pursuant to Title XVIII of the federal Social Security Act.

(11) A provider of independent laboratory services shall be reimbursed on the basis of competitive bidding or for the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency.

(12)(a) A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(b) The agency shall adopt a fee schedule, subject to any limitations or directions provided for in the General Appropriations Act, based on a resource-based relative value scale for pricing Medicaid physician services. Under this fee schedule, physicians shall be paid a dollar amount for each service based on the average resources required to provide the service, including, but not limited to, estimates of average physician time and effort, practice expense, and the costs of professional liability insurance. The fee schedule shall provide increased reimbursement for preventive and primary care services and lowered reimbursement for specialty services by using at least two conversion factors, one for cognitive services and another for procedural services. The fee schedule shall not increase total Medicaid physician expenditures unless funds are specifically provided for such increase. However, in no case may any increase result in physicians being paid more than the Medicare fee ~~moneys are available, and shall be phased in over a 2-year period beginning on July 1, 1994. The Agency for Health Care Administration shall seek the advice of a 16-member advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458 and 459 and shall be composed of 50 percent primary care physicians and 50 percent specialty care physicians~~.

(c) Notwithstanding paragraph (b), reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which include prenatal, delivery, and postpartum care, shall be at least $1,500 per delivery for a pregnant woman with low medical risk and at least $2,000 per delivery for a pregnant woman with high medical risk. However, reimbursement to physicians working in Regional Perinatal

Intensive Care Centers designated pursuant to chapter 383, for services to certain pregnant Medicaid recipients with a high medical risk, may be made according to obstetrical care and neonatal care groupings and rates established by the agency. Nurse midwives licensed under part I of chapter 464 or midwives licensed under chapter 467 shall be reimbursed at no less than 80 percent of the low medical risk fee. The agency shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman and shall not pay more based solely on the fact that a caesarean section was performed, rather than a vaginal delivery. The agency shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed. The Department of Health shall adopt rules for appropriate insurance coverage for midwives licensed under chapter 467. Prior to the issuance and renewal of an active license, or reactivation of an inactive license for midwives licensed under chapter 467, such licensees shall submit proof of coverage with each application.

(13) Medicare premiums for persons eligible for both Medicare and Medicaid coverage shall be paid at the rates established by Title XVIII of the Social Security Act. For Medicare services rendered to Medicaid-eligible persons, Medicaid shall pay Medicare deductibles and coinsurance as follows:

(a) Medicaid shall make no payment toward deductibles and coinsurance for any service that is not covered by Medicaid.

(b) Medicaid's financial obligation for deductibles and coinsurance payments shall be based on Medicare allowable fees, not on a provider's billed charges.

(c) Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor. The Legislature finds that there has been confusion regarding the reimbursement for services rendered to dually eligible Medicare beneficiaries. Accordingly, the Legislature clarifies that it has always been the intent of the Legislature before and after 1991 that, in reimbursing in accordance with fees established by Title XVIII for premiums, deductibles, and coinsurance for Medicare services rendered by physicians to Medicaid eligible persons, physicians be reimbursed at the lesser of the amount billed by the physician or the Medicaid maximum allowable fee established by the Agency for Health Care Administration, as is permitted by federal law. It has never been the intent of the Legislature with regard to such services rendered by physicians that Medicaid be required to provide any payment for deductibles, coinsurance, or copayments for Medicare cost sharing, or any expenses incurred relating thereto, in excess of the payment amount provided for under the State Medicaid plan for such service. This payment methodology is applicable even in those situations in which the payment for Medicare cost sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated. This expression of the Legislature is in clarification of existing law and shall apply to payment for,

and with respect to provider agreements with respect to, items or services furnished on or after the effective date of this act. This paragraph applies to payment by Medicaid for items and services furnished before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of this section, and that is pending as of, or is initiated after, the effective date of this act.

(d) Notwithstanding ~~The following provisions are exceptions to~~ paragraphs (a)-(c):

1. Medicaid payments for Nursing Home Medicare part A coinsurance shall be the lesser of the Medicare coinsurance amount or the Medicaid nursing home per diem rate.

~~2. Medicaid shall pay all deductibles and coinsurance for Nursing Home Medicare part B services.~~

2.~~3.~~ Medicaid shall pay all deductibles and coinsurance for Medicare-eligible recipients receiving freestanding end stage renal dialysis center services.

~~4. Medicaid shall pay all deductibles and coinsurance for hospital outpatient Medicare part B services.~~

3.~~5.~~ Medicaid payments for general hospital inpatient services shall be limited to the Medicare deductible per spell of illness. Medicaid shall make no payment toward coinsurance for Medicare general hospital inpatient services.

4.~~6.~~ Medicaid shall pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to chapter 401.

(14) A provider of prescribed drugs shall be reimbursed on the basis of competitive bidding or for the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The

agency is directed to implement a variable dispensing fee for payments for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider and the volume of prescriptions dispensed to an individual recipient. The agency is authorized to limit reimbursement for prescribed medicine in order to comply with any limitations or directions provided for in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

(15) A provider of primary care case management services rendered pursuant to a federally approved waiver shall be reimbursed by payment of a fixed, prepaid monthly sum for each Medicaid recipient enrolled with the provider.

(16) A provider of rural health clinic services and federally qualified health center services shall be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the agency in accordance with federal regulations.

(17) A provider of targeted case management services shall be reimbursed pursuant to an established fee, except where the Federal Government requires a public provider be reimbursed on the basis of average actual costs.

(18) Unless otherwise provided for in the General Appropriations Act, a provider of transportation services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency, except when the agency has entered into a direct contract with the provider, or with a community transportation coordinator, for the provision of an all-inclusive service, or

when services are provided pursuant to an agreement negotiated between the agency and the provider. The agency, as provided for in s. 427.0135, shall purchase transportation services through the community coordinated transportation system, if available, unless the agency determines a more cost-effective method for Medicaid clients. Nothing in this subsection shall be construed to limit or preclude the agency from contracting for services using a prepaid capitation rate or from establishing maximum fee schedules, individualized reimbursement policies by provider type, negotiated fees, prior authorization, competitive bidding, increased use of mass transit, or any other mechanism that the agency considers efficient and effective for the purchase of services on behalf of Medicaid clients, including implementing a transportation eligibility process. The agency shall not be required to contract with any community transportation coordinator or transportation operator that has been determined by the agency, the Department of Legal Affairs Medicaid Fraud Control Unit, or any other state or federal agency to have engaged in any abusive or fraudulent billing activities. The agency is authorized to competitively procure transportation services or make other changes necessary to secure approval of federal waivers needed to permit federal financing of Medicaid transportation services at the service matching rate rather than the administrative matching rate.

(19) County health department services may be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the agency in accordance with federal regulations under the authority of 42 C.F.R. s. 431.615.

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

(21) The agency shall reimburse school districts which certify the state match pursuant to ss. 236.0812 and 409.9071 for the federal portion of the school district's allowable costs to deliver the services, based on the reimbursement schedule. The school district shall determine the costs for delivering services as authorized in ss. 236.0812 and 409.9071 for which the state match will be certified. Reimbursement of school-based providers is contingent on such providers being enrolled as Medicaid providers and meeting the qualifications contained in 42 C.F.R. s. 440.110, unless otherwise waived by the federal Health Care Financing Administration. Speech therapy providers who are certified through the Department of Education pursuant to rule 6A-4.0176, Florida Administrative Code, are eligible for reimbursement for services that are provided on school premises. Any employee of the school district who has been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines shall be exempt from any agency requirements relating to criminal background checks. Elementary, middle, and secondary schools affiliated with Florida universities may separately enroll in the Medicaid certified school match program and may certify local expenditures for Medicaid school health services and the administrative claiming program.

(22) Reimbursement to state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under chapter 393 must be made prospectively.

Section 9. Paragraph (c) of subsection (1), paragraph (b) of subsection (3), and subsection (7) of section 409.911, Florida Statutes, are amended to read:

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

(1) Definitions.--As used in this section and s. 409.9112:

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

(3) In computing the disproportionate share rate:

(b) The agency shall use 1994 ~~the most recent calendar year~~ audited financial data ~~available at the beginning of each state fiscal year~~ for the calculation of disproportionate share payments under this section.

(7) ~~For fiscal year 1991-1992 and all years other than 1992-1993,~~The following criteria shall be used in determining the disproportionate share percentage:

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

(b) If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, then the disproportionate share percentage is 1.8478498 ~~2.1544347~~.

(c) If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, then the disproportionate share percentage is 3.4145488 ~~4.6415888766~~.

(d) If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, then the disproportionate share percentage is 6.3095734 ~~10.0000001388~~.

(e) If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, then the disproportionate share percentage is 11.6591440 ~~21.544347299~~.

(f) If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, then the disproportionate share percentage is 73.5642254 ~~46.41588941~~.

(g) If the disproportionate share rate is greater than or equal to 60 percent but less than 72.5 percent, then the disproportionate share percentage is 135.9356391 ~~100~~.

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

Section 10. Section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee; restricted drug formulary.--There is created a

Medicaid Pharmaceutical and Therapeutics Committee for the purpose of developing a restricted drug formulary. ~~The committee shall develop and implement a voluntary Medicaid preferred prescribed drug designation program.~~The program established under this section shall provide information to Medicaid providers on medically appropriate and cost-efficient prescription drug therapies through the development and publication of a restricted drug formulary ~~voluntary Medicaid preferred prescribed-drug list~~.

(1) The Medicaid Pharmaceutical and Therapeutics Committee shall be comprised of nine members as specified in 42 U.S.C. s. 1396 ~~appointed as follows: one practicing physician licensed under chapter 458, appointed by the Speaker of the House of Representatives from a list of recommendations from the Florida Medical Association; one practicing physician licensed under chapter 459, appointed by the Speaker of the House of Representatives from a list of recommendations from the Florida Osteopathic Medical Association; one practicing physician licensed under chapter 458, appointed by the President of the Senate from a list of recommendations from the Florida Academy of Family Physicians; one practicing podiatric physician licensed under chapter 461, appointed by the President of the Senate from a list of recommendations from the Florida Podiatric Medical Association; one trauma surgeon licensed under chapter 458, appointed by the Speaker of the House of Representatives from a list of recommendations from the American College of Surgeons; one practicing dentist licensed under chapter 466, appointed by the President of the Senate from a list of recommendations from the Florida Dental Association; one practicing pharmacist licensed under chapter 465, appointed by the Governor from a list of recommendations~~

~~from the Florida Pharmacy Association; one practicing pharmacist licensed under chapter 465, appointed by the Governor from a list of recommendations from the Florida Society of Health System Pharmacists; and one health care professional with expertise in clinical pharmacology appointed by the Governor from a list of recommendations from the Pharmaceutical Research and Manufacturers Association~~. The members shall be appointed to serve for terms of 2 years from the date of their appointment. Members may be appointed to more than one term. The Agency for Health Care Administration shall serve as staff for the committee and assist them with all ministerial duties.

(2) With the advice of ~~Upon recommendation by~~ the committee, the Agency for Health Care Administration shall establish a restricted drug formulary ~~the voluntary Medicaid preferred prescribed-drug list. Upon further recommendation by the committee, the agency shall add to, delete from, or modify the list~~. The committee shall also review requests for additions to, deletions from, or modifications of the formulary as presented to it by the agency; and, upon further recommendation by the committee, the agency shall add to, delete from, or modify the formulary as appropriate ~~list. The list shall be adopted by the committee in consultation with medical specialists, when appropriate, using the following criteria: use of the list shall be voluntary by providers and the list must provide for medically appropriate drug therapies for Medicaid patients which achieve cost savings in the Medicaid program~~.

(3) The Agency for Health Care Administration shall publish and disseminate the restricted drug formulary

~~voluntary Medicaid preferred prescribed drug list~~ to all Medicaid prescribing providers in the state.

Section 11. Subsection (2) of section 409.9116, Florida Statutes, is amended to read:

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

(2) The agency shall use the following formula for distribution of funds for the disproportionate share/financial assistance program for rural hospitals:

(a) The agency shall first determine a preliminary payment amount for each rural hospital by allocating all available state funds using the following formula:

PDAER = (TAERH x TARH)/STAERH

Where:

PDAER = preliminary distribution amount for each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section.

STAERH = sum of total amount earned by each rural hospital.

(b) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in paragraph (a).

(c) The state-funds-only payment amount shall then be calculated for each hospital using the following formula:

SFOER = Maximum value of (1) SFOL - PDAER or (2) 0

Where:

SFOER = state-funds-only payment amount for each rural hospital.

SFOL = state-funds-only payment level, which is set at 4 percent of TARH.

In calculating the SFOER, PDAER includes federal matching funds from paragraph (b).

(d) The adjusted total amount allocated to the rural disproportionate share program shall then be calculated using the following formula:

ATARH = (TARH - SSFOER)

Where:

ATARH = adjusted total amount appropriated or distributed under this section.

SSFOER = sum of the state-funds-only payment amount calculated under paragraph (c) for all rural hospitals.

(e) The distribution of the adjusted total amount of rural disproportionate share hospital funds shall then be calculated using the following formula:

DAERH = [(TAERH x ATARH)/STAERH]

Where:

DAERH = distribution amount for each rural hospital.

(f) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in paragraph (e).

(g) State-funds-only payment amounts calculated under paragraph (c) and corresponding federal matching funds are then added to the results of paragraph (f) to determine the total distribution amount for each rural hospital. ~~In determining the payment amount for each rural hospital under this section, the agency shall first allocate all available state funds by the following formula:~~

~~DAER = (TAERH x TARH)/STAERH~~

~~Where:~~

~~DAER = distribution amount for each rural hospital.~~

~~STAERH = sum of total amount earned by each rural hospital.~~

~~TAERH = total amount earned by each rural hospital.~~

~~TARH = total amount appropriated or distributed under this section.~~

~~Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share payments under this section.~~

Section 12. Paragraph (b) of subsection (3), subsections (26) and (34), and paragraph (a) of subsection (37) of section 409.912, Florida Statutes, are amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(3) The agency may contract with:

(b) An entity that <u>provides</u> ~~is providing~~ comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral

health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services. The agency may continue to 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 or until the agency determines that a capitated arrangement will not adversely affect the availability of substance abuse treatment services.

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

~~2. By December 31, 2001, the agency shall contract with entities providing comprehensive behavioral health care services to Medicaid recipients through capitated, prepaid~~

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

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

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

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

(26) The agency shall conduct ~~perform choice counseling,~~ enrollments~~,~~ and disenrollments for ~~Medicaid recipients who are eligible for~~ MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (18)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. ~~The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives.~~ The agency may contract with a third party to perform managed care plan and MediPass ~~choice-counseling,~~ 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 choice-counseling, enrollment, and disenrollment contract, and for agency supervision and management of the managed care plan choice-counseling, enrollment, and disenrollment contract.~~

(34) The agency may provide for cost-effective purchasing of home health services, hospital inpatient and outpatient services, private duty nursing services, independent laboratory services, durable medical equipment and supplies, nursing home services, other long-term care

services, and prescribed drug services through competitive bidding ~~negotiation~~ pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid such ~~home health~~ services. The agency may exclude providers not selected through the bidding process from the Medicaid provider network.

(37)(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 not residing in nursing homes or other institutions is limited to the dispensing of four brand-name drugs per month per recipient. Children and institutionalized adults 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. The agency may authorize exceptions to the brand-name-drug restriction or to the restricted drug formulary, 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; and

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.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lowest of the average wholesale price less 13.25 percent, the wholesaler acquisition cost plus 7 percent, the federal or state pricing limit, or the provider's usual and customary charge.

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.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location,

size, patient educational programs, patient consultation, disease-management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers.

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

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

7. The agency may establish a restricted drug formulary in accordance with 42 U.S.C. s. 1396r and, pursuant to the establishment of such formulary, is authorized to negotiate supplemental rebates from manufacturers at no less than 10 percent of the average wholesale price on the last day

of each quarter. State supplemental manufacturer rebates shall be invoiced concurrently with federal rebates.

Section 13. Paragraph (a) of subsection (1) and subsection (7) of section 409.915, Florida Statutes, are amended to read:

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

(1) Each county shall participate in the following items of care and service:

(a) Payments for inpatient hospitalization in excess of 10 ~~12~~ days, but not in excess of 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program.

(7) Counties are exempt from contributing toward the cost of new exemptions on inpatient ceilings for statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals that came into effect July 1, 2000, and for special Medicaid payments that came into effect on or after July 1, 2000. ~~Notwithstanding any provision of this section to the contrary, counties are exempt from contributing toward the increased cost of hospital inpatient services due to the elimination of ceilings on Medicaid inpatient reimbursement rates paid to teaching hospitals, specialty hospitals, and community health education program hospitals and for special Medicaid reimbursements to hospitals for which the Legislature has specifically~~

~~appropriated funds. This subsection is repealed on July 1, 2001.~~

Section 14. Section 636.0145, Florida Statutes, is repealed:

~~636.0145 Certain entities contracting with Medicaid.--Notwithstanding the requirements of s. 409.912(3)(b), an entity that is providing comprehensive inpatient and outpatient mental health care services to certain Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties through a capitated, prepaid arrangement pursuant to the federal waiver provided for in s. 409.905(5) must become licensed under chapter 636 by December 31, 1998. Any entity licensed under this chapter which provides services solely to Medicaid recipients under a contract with Medicaid shall be exempt from ss. 636.017, 636.018, 636.022, 636.028, and 636.034.~~

Section 15. The Legislature determines and declares that this act fulfills an important state interest.

Section 16. This act shall take effect July 1, 2001.

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HOUSE SUMMARY

Revises various provisions relating to duties of the Agency for Health Care Administration with respect to Medicaid. Deletes the requirement to provide recipients counseling regarding choice among health care provider options. Revises Medicaid eligibility requirements for pregnant women and children under age 1. Revises Medicaid eligibility requirements for certain elderly or disabled persons. Revises Medicaid eligibility requirements of postpartum women for family planning services. Authorizes payment for health insurance premiums of eligible individuals if cost-effective. Updates provisions relating to hospital inpatient behavioral health services provided pursuant to a federally approved waiver and expands provision of such services statewide. Deletes adult denture services as optional Medicaid services and restricts authorized hearing and visual services to children. Provides additional requirements for authorized intermediate care services. Adds assistive care services as an optional Medicaid service for recipients in certain residential living settings. Provides for reimbursement of hospital inpatient and outpatient services at certain rates. Prohibits increases in reimbursement rates to nursing homes associated with changes in ownership. Precludes premium adjustments to managed care organizations under certain circumstances. Revises provisions relating to physician reimbursement and the reimbursement fee schedule. Deletes certain preferential Medicaid payments for dually eligible recipients. Authorizes competitive procurement of transportation services or the securing through waivers of federal financing of transportation services at certain rates. Authorizes public schools affiliated with Florida universities to separately enroll in the Medicaid certified school match program and certify local expenditures therefor. Updates data requirements and share rates for disproportionate share distributions and modifies the formula for disproportionate share/financial assistance distributions to rural hospitals. Revises provisions relating to the membership of the Medicaid Pharmaceutical and Therapeutics Committee. Provides for establishment of a restricted drug formulary for Medicaid providers, authorizes exemptions therefrom, and authorizes negotiation of supplemental rebates from drug manufacturers pursuant thereto. Authorizes continued reimbursement of substance abuse treatment services on a fee-for-service basis under certain conditions. Deletes authorization to test new marketing initiatives relating to managed care options. Deletes a restriction on adjustment of capitation rates. Permits competitive bidding for certain services. Modifies reimbursement to pharmacies. Requires prescriptions for Medicaid recipients to be on certain standardized forms. Increases county contributions to Medicaid for inpatient hospitalization. Exempts counties from contributing toward the cost of inpatient services provided by certain hospitals and for special Medicaid payments under certain

conditions. Provides a finding of important state interest. See bill for details.