Amendment No. ___ (for drafter's use only)

CHAMBER ACTION

Senate		House
	.	

ORIGINAL STAMP BELOW

Representative(s) Frankel offered the following:

Amendment (with title amendment)

Remove from the bill: Everything after the enacting clause

and insert in lieu thereof:

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

1 Medikids applicant who has not chosen a managed care plan or
2 MediPass provider after the applicant's voluntary choice
3 period ends. An applicant may select MediPass under the
4 Medikids program component only in counties that have fewer
5 than two managed care plans available to serve Medicaid
6 recipients and only if the federal Health Care Financing
7 Administration determines that MediPass constitutes "health
8 insurance coverage" as defined in Title XXI of the Social
9 Security Act.
10 Section 2. Subsection (9) is added to section 40.904,
11 Florida Statutes, to read:
12 409.904 Optional payments for eligible persons.--The
13 agency may make payments for medical assistance and related
14 services on behalf of the following persons who are determined
15 to be eligible subject to the income, assets, and categorical
16 eligibility tests set forth in federal and state law. Payment
17 on behalf of these Medicaid-eligible persons is subject to the
18 availability of moneys and any limitations established by the
19 General Appropriations Act or chapter 216.
20 (9) A Medicaid-eligible individual for the
21 individual's health insurance premiums, if the agency
22 determines that such payments are cost-effective.
23 Section 3. Subsection (5) of section 409.905, Florida
24 Statutes, is amended to read:
25 409.905 Mandatory Medicaid services.--The agency may
26 make payments for the following services, which are required
27 of the state by Title XIX of the Social Security Act,
28 furnished by Medicaid providers to recipients who are
29 determined to be eligible on the dates on which the services
30 were provided. Any service under this section shall be
31 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; 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

1 behavioral health ~~hospitalization~~ services ~~for mental health~~
2 ~~reasons~~ to children and adults in the most cost-effective and
3 lowest cost setting possible. Such waiver shall include a
4 request for the opportunity to pay for care in hospitals known
5 under federal law as "institutions for mental disease" or
6 "IMD's." The behavioral health waiver proposal shall propose
7 no additional aggregate cost to the state or Federal
8 Government~~, and shall be conducted in Hillsborough County,~~
9 ~~Highlands County, Hardee County, Manatee County, and Polk~~
10 ~~County~~. Implementation of the behavioral health waiver
11 proposal shall not be the basis for adjusting a hospital's
12 Medicaid inpatient or outpatient rate.The waiver proposal may
13 incorporate competitive bidding for hospital services,
14 comprehensive brokering, prepaid capitated arrangements, or
15 other mechanisms deemed by the department to show promise in
16 reducing the cost of acute care and increasing the
17 effectiveness of preventive care. ~~When developing~~ The waiver
18 proposal~~, the department~~ shall take into account price,
19 quality, accessibility, linkages of the hospital to community
20 services and family support programs, plans of the hospital to
21 ensure the earliest discharge possible, and the
22 comprehensiveness of the mental health and other health care
23 services offered by participating providers.
24 ~~(c) Agency for Health Care Administration shall adjust~~
25 ~~a hospital's current inpatient per diem rate to reflect the~~
26 ~~cost of serving the Medicaid population at that institution~~
27 ~~if:~~
28 ~~1. The hospital experiences an increase in Medicaid~~
29 ~~caseload by more than 25 percent in any year, primarily~~
30 ~~resulting from the closure of a hospital in the same service~~
31 ~~area occurring after July 1, 1995; or~~

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1 ~~2. The hospital's Medicaid per diem rate is at least~~
2 ~~25 percent below the Medicaid per patient cost for that year.~~
3
4 ~~No later than November 1, 2000, the agency must provide~~
5 ~~estimated costs for any adjustment in a hospital inpatient per~~
6 ~~diem pursuant to this paragraph to the Executive Office of the~~
7 ~~Governor, the House of Representatives General Appropriations~~
8 ~~Committee, and the Senate Budget Committee. Before the agency~~
9 ~~implements a change in a hospital's inpatient per diem rate~~
10 ~~pursuant to this paragraph, the Legislature must have~~
11 ~~specifically appropriated sufficient funds in the 2001-2002~~
12 ~~General Appropriations Act to support the increase in cost as~~
13 ~~estimated by the agency. This paragraph is repealed on July 1,~~
14 ~~2001.~~
15 Section 4. Subsection (16) of Section 409.906, Florida
16 Statutes, is amended, and subsection (25) is added to said
17 subsection, to read:
18 409.906 Optional Medicaid services.--Subject to
19 specific appropriations, the agency may make payments for
20 services which are optional to the state under Title XIX of
21 the Social Security Act and are furnished by Medicaid
22 providers to recipients who are determined to be eligible on
23 the dates on which the services were provided. Any optional
24 service that is provided shall be provided only when medically
25 necessary and in accordance with state and federal law.
26 Nothing in this section shall be construed to prevent or limit
27 the agency from adjusting fees, reimbursement rates, lengths
28 of stay, number of visits, or number of services, or making
29 any other adjustments necessary to comply with the
30 availability of moneys and any limitations or directions
31 provided for in the General Appropriations Act or chapter 216.

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1 If necessary to safeguard the state's systems of providing
2 services to elderly and disabled persons and subject to the
3 notice and review provisions of s. 216.177, the Governor may
4 direct the Agency for Health Care Administration to amend the
5 Medicaid state plan to delete the optional Medicaid service
6 known as "Intermediate Care Facilities for the Developmentally
7 Disabled." Optional services may include:
8 (16) INTERMEDIATE CARE SERVICES.--The agency may pay
9 for 24-hour-a-day intermediate care nursing and rehabilitation
10 services rendered to a recipient in a nursing facility
11 licensed under part II of chapter 400, if the services are
12 ordered by and provided under the direction of a physician,
13 meet nursing home level of care criteria as determined by the
14 Comprehensive Assessment and Review Long-Term Care (CARE)
15 Program of the Department of Elderly Affairs, and do not meet
16 the definition of "general care" as used in the Medicaid
17 budget estimating process.
18 (25) ASSISTIVE CARE SERVICES.--The agency may pay for
19 assistive care services provided to recipients with functional
20 or cognitive impairments residing in assisted living
21 facilities, adult family-care homes, or residential treatment
22 facilities with 16 or fewer beds. These services may include
23 health support, assistance with the activities of daily living
24 and the instrumental acts of daily living, assistance with
25 medication administration, and arrangements for health care.
26 Section 5. Section 409.908, Florida Statutes, is
27 amended to read:
28 409.908 Reimbursement of Medicaid providers.--Subject
29 to specific appropriations, the agency shall reimburse
30 Medicaid providers, in accordance with state and federal law,
31 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. 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.

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

1 hospital is located in a county that does not have any
2 community nursing homes, reimbursement must be determined by
3 averaging the nursing home payments, in counties that surround
4 the county in which the hospital is located. Reimbursement to
5 hospitals, including Medicaid payment of Medicare copayments,
6 for skilled nursing services shall be limited to 30 days,
7 unless a prior authorization has been obtained from the
8 agency. Medicaid reimbursement may be extended by the agency
9 beyond 30 days, and approval must be based upon verification
10 by the patient's physician that the patient requires
11 short-term rehabilitative and recuperative services only, in
12 which case an extension of no more than 15 days may be
13 approved. Reimbursement to a hospital licensed under ~~part I of~~
14 chapter 395 for the temporary provision of skilled nursing
15 services to nursing home residents who have been displaced as
16 the result of a natural disaster or other emergency may not
17 exceed the average county nursing home payment for those
18 services in the county in which the hospital is located and is
19 limited to the period of time which the agency considers
20 necessary for continued placement of the nursing home
21 residents in the hospital.
22 (b) Subject to any limitations or directions provided
23 for in the General Appropriations Act, the agency shall
24 establish and implement a Florida Title XIX Long-Term Care
25 Reimbursement Plan (Medicaid) for nursing home care in order
26 to provide care and services in conformance with the
27 applicable state and federal laws, rules, regulations, and
28 quality and safety standards and to ensure that individuals
29 eligible for medical assistance have reasonable geographic
30 access to such care. The agency shall not provide for any
31 increases in reimbursement rates to nursing homes associated

1 with changes in ownership.Under the plan, interim rate
2 adjustments shall not be granted to reflect increases in the
3 cost of general or professional liability insurance for
4 nursing homes unless the following criteria are met: have at
5 least a 65 percent Medicaid utilization in the most recent
6 cost report submitted to the agency, and the increase in
7 general or professional liability costs to the facility for
8 the most recent policy period affects the total Medicaid per
9 diem by at least 5 percent. This rate adjustment shall not
10 result in the per diem exceeding the class ceiling. This
11 provision shall apply only to fiscal year 2000-2001 and shall
12 be implemented to the extent existing appropriations are
13 available. The agency shall report to the Governor, the
14 Speaker of the House of Representatives, and the President of
15 the Senate by December 31, 2000, on the cost of liability
16 insurance for Florida nursing homes for fiscal years 1999 and
17 2000 and the extent to which these costs are not being
18 compensated by the Medicaid program. Medicaid-participating
19 nursing homes shall be required to report to the agency
20 information necessary to compile this report. Effective no
21 earlier than the rate-setting period beginning April 1, 1999,
22 the agency shall establish a case-mix reimbursement
23 methodology for the rate of payment for long-term care
24 services for nursing home residents. The agency shall compute
25 a per diem rate for Medicaid residents, adjusted for case mix,
26 which is based on a resident classification system that
27 accounts for the relative resource utilization by different
28 types of residents and which is based on level-of-care data
29 and other appropriate data. The case-mix methodology developed
30 by the agency shall take into account the medical, behavioral,
31 and cognitive deficits of residents. In developing the

1 reimbursement methodology, the agency shall evaluate and
2 modify other aspects of the reimbursement plan as necessary to
3 improve the overall effectiveness of the plan with respect to
4 the costs of patient care, operating costs, and property
5 costs. In the event adequate data are not available, the
6 agency is authorized to adjust the patient's care component or
7 the per diem rate to more adequately cover the cost of
8 services provided in the patient's care component. The agency
9 shall work with the Department of Elderly Affairs, the Florida
10 Health Care Association, and the Florida Association of Homes
11 for the Aging in developing the methodology. It is the intent
12 of the Legislature that the reimbursement plan achieve the
13 goal of providing access to health care for nursing home
14 residents who require large amounts of care while encouraging
15 diversion services as an alternative to nursing home care for
16 residents who can be served within the community. The agency
17 shall base the establishment of any maximum rate of payment,
18 whether overall or component, on the available moneys as
19 provided for in the General Appropriations Act. The agency may
20 base the maximum rate of payment on the results of
21 scientifically valid analysis and conclusions derived from
22 objective statistical data pertinent to the particular maximum
23 rate of payment.
24 (3) Subject to any limitations or directions provided
25 for in the General Appropriations Act, the following Medicaid
26 services and goods may be reimbursed on a fee-for-service
27 basis. For each allowable service or goods furnished in
28 accordance with Medicaid rules, policy manuals, handbooks, and
29 state and federal law, the payment shall be the amount billed
30 by the provider, the provider's usual and customary charge, or
31 the maximum allowable fee established by the agency, whichever

1 amount is less, with the exception of those services or goods
2 for which the agency makes payment using a methodology based
3 on capitation rates, average costs, or negotiated fees.
4 (a) Advanced registered nurse practitioner services.
5 (b) Birth center services.
6 (c) Chiropractic services.
7 (d) Community mental health services.
8 (e) Dental services, including oral and maxillofacial
9 surgery.
10 (f) Durable medical equipment.
11 (g) Hearing services.
12 (h) Occupational therapy for Medicaid recipients under
13 age 21.
14 (i) Optometric services.
15 (j) Orthodontic services.
16 (k) Personal care for Medicaid recipients under age
17 21.
18 (l) Physical therapy for Medicaid recipients under age
19 21.
20 (m) Physician assistant services.
21 (n) Podiatric services.
22 (o) Portable X-ray services.
23 (p) Private-duty nursing for Medicaid recipients under
24 age 21.
25 (q) Registered nurse first assistant services.
26 (r) Respiratory therapy for Medicaid recipients under
27 age 21.
28 (s) Speech therapy for Medicaid recipients under age
29 21.
30 (t) Visual services.
31 (4) Subject to any limitations or directions provided

1 for in the General Appropriations Act, alternative health
2 plans, health maintenance organizations, and prepaid health
3 plans shall be reimbursed a fixed, prepaid amount negotiated,
4 or competitively bid pursuant to s. 287.057, by the agency and
5 prospectively paid to the provider monthly for each Medicaid
6 recipient enrolled. The amount may not exceed the average
7 amount the agency determines it would have paid, based on
8 claims experience, for recipients in the same or similar
9 category of eligibility. The agency shall calculate
10 capitation rates on a regional basis and, beginning September
11 1, 1995, shall include age-band differentials in such
12 calculations. Effective July 1, 2001, the cost of exempting
13 statutory teaching hospitals, specialty hospitals, and
14 community hospital education program hospitals from
15 reimbursement ceilings and the cost of special Medicaid
16 payments shall not be included in premiums paid to health
17 maintenance organizations or prepaid health care plans.
18 (5) An ambulatory surgical center shall be reimbursed
19 the lesser of the amount billed by the provider or the
20 Medicare-established allowable amount for the facility.
21 (6) A provider of early and periodic screening,
22 diagnosis, and treatment services to Medicaid recipients who
23 are children under age 21 shall be reimbursed using an
24 all-inclusive rate stipulated in a fee schedule established by
25 the agency. A provider of the visual, dental, and hearing
26 components of such services shall be reimbursed the lesser of
27 the amount billed by the provider or the Medicaid maximum
28 allowable fee established by the agency.
29 (7) A provider of family planning services shall be
30 reimbursed the lesser of the amount billed by the provider or
31 an all-inclusive amount per type of visit for physicians and

1 advanced registered nurse practitioners, as established by the
2 agency in a fee schedule.
3 (8) A provider of home-based or community-based
4 services rendered pursuant to a federally approved waiver
5 shall be reimbursed based on an established or negotiated rate
6 for each service. These rates shall be established according
7 to an analysis of the expenditure history and prospective
8 budget developed by each contract provider participating in
9 the waiver program, or under any other methodology adopted by
10 the agency and approved by the Federal Government in
11 accordance with the waiver. Effective July 1, 1996, privately
12 owned and operated community-based residential facilities
13 which meet agency requirements and which formerly received
14 Medicaid reimbursement for the optional intermediate care
15 facility for the mentally retarded service may participate in
16 the developmental services waiver as part of a
17 home-and-community-based continuum of care for Medicaid
18 recipients who receive waiver services.
19 (9) A provider of home health care services or of
20 medical supplies and appliances shall be reimbursed on the
21 basis of competitive bidding or for the lesser of the amount
22 billed by the provider or the agency's established maximum
23 allowable amount, except that, in the case of the rental of
24 durable medical equipment, the total rental payments may not
25 exceed the purchase price of the equipment over its expected
26 useful life or the agency's established maximum allowable
27 amount, whichever amount is less.
28 (10) A hospice shall be reimbursed through a
29 prospective system for each Medicaid hospice patient at
30 Medicaid rates using the methodology established for hospice
31 reimbursement pursuant to Title XVIII of the federal Social

1 Security Act.
2 (11) A provider of independent laboratory services
3 shall be reimbursed the least of the amount billed by the
4 provider, the provider's usual and customary charge, or the
5 Medicaid maximum allowable fee established by the agency.
6 (12)(a) A physician shall be reimbursed the lesser of
7 the amount billed by the provider or the Medicaid maximum
8 allowable fee established by the agency.
9 (b) The agency shall adopt a fee schedule, subject to
10 any limitations or directions provided for in the General
11 Appropriations Act, based on a resource-based relative value
12 scale for pricing Medicaid physician services. Under this fee
13 schedule, physicians shall be paid a dollar amount for each
14 service based on the average resources required to provide the
15 service, including, but not limited to, estimates of average
16 physician time and effort, practice expense, and the costs of
17 professional liability insurance. The fee schedule shall
18 provide increased reimbursement for preventive and primary
19 care services and lowered reimbursement for specialty services
20 by using at least two conversion factors, one for cognitive
21 services and another for procedural services. The fee
22 schedule shall not increase total Medicaid physician
23 expenditures unless funds are specifically provided for such
24 increase. However, in no case may any increase result in
25 physicians being paid more than the Medicare fee ~~moneys are~~
26 ~~available, and shall be phased in over a 2-year period~~
27 ~~beginning on July 1, 1994. The Agency for Health Care~~
28 ~~Administration shall seek the advice of a 16-member advisory~~
29 ~~panel in formulating and adopting the fee schedule. The panel~~
30 ~~shall consist of Medicaid physicians licensed under chapters~~
31 ~~458 and 459 and shall be composed of 50 percent primary care~~

1 ~~physicians and 50 percent specialty care physicians~~.
2 (c) Notwithstanding paragraph (b), reimbursement fees
3 to physicians for providing total obstetrical services to
4 Medicaid recipients, which include prenatal, delivery, and
5 postpartum care, shall be at least $1,500 per delivery for a
6 pregnant woman with low medical risk and at least $2,000 per
7 delivery for a pregnant woman with high medical risk. However,
8 reimbursement to physicians working in Regional Perinatal
9 Intensive Care Centers designated pursuant to chapter 383, for
10 services to certain pregnant Medicaid recipients with a high
11 medical risk, may be made according to obstetrical care and
12 neonatal care groupings and rates established by the agency.
13 Nurse midwives licensed under part I of chapter 464 or
14 midwives licensed under chapter 467 shall be reimbursed at no
15 less than 80 percent of the low medical risk fee. The agency
16 shall by rule determine, for the purpose of this paragraph,
17 what constitutes a high or low medical risk pregnant woman and
18 shall not pay more based solely on the fact that a caesarean
19 section was performed, rather than a vaginal delivery. The
20 agency shall by rule determine a prorated payment for
21 obstetrical services in cases where only part of the total
22 prenatal, delivery, or postpartum care was performed. The
23 Department of Health shall adopt rules for appropriate
24 insurance coverage for midwives licensed under chapter 467.
25 Prior to the issuance and renewal of an active license, or
26 reactivation of an inactive license for midwives licensed
27 under chapter 467, such licensees shall submit proof of
28 coverage with each application.
29 (13) Medicare premiums for persons eligible for both
30 Medicare and Medicaid coverage shall be paid at the rates
31 established by Title XVIII of the Social Security Act. For

1 Medicare services rendered to Medicaid-eligible persons,
2 Medicaid shall pay Medicare deductibles and coinsurance as
3 follows:
4 (a) Medicaid shall make no payment toward deductibles
5 and coinsurance for any service that is not covered by
6 Medicaid.
7 (b) Medicaid's financial obligation for deductibles
8 and coinsurance payments shall be based on Medicare allowable
9 fees, not on a provider's billed charges.
10 (c) Medicaid will pay no portion of Medicare
11 deductibles and coinsurance when payment that Medicare has
12 made for the service equals or exceeds what Medicaid would
13 have paid if it had been the sole payor. The combined payment
14 of Medicare and Medicaid shall not exceed the amount Medicaid
15 would have paid had it been the sole payor. The Legislature
16 finds that there has been confusion regarding the
17 reimbursement for services rendered to dually eligible
18 Medicare beneficiaries. Accordingly, the Legislature clarifies
19 that it has always been the intent of the Legislature before
20 and after 1991 that, in reimbursing in accordance with fees
21 established by Title XVIII for premiums, deductibles, and
22 coinsurance for Medicare services rendered by physicians to
23 Medicaid eligible persons, physicians be reimbursed at the
24 lesser of the amount billed by the physician or the Medicaid
25 maximum allowable fee established by the Agency for Health
26 Care Administration, as is permitted by federal law. It has
27 never been the intent of the Legislature with regard to such
28 services rendered by physicians that Medicaid be required to
29 provide any payment for deductibles, coinsurance, or
30 copayments for Medicare cost sharing, or any expenses incurred
31 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

1 provided by ambulances licensed pursuant to chapter 401.
2 (14) A provider of prescribed drugs shall be
3 reimbursed the least of the amount billed by the provider, the
4 provider's usual and customary charge, or the Medicaid maximum
5 allowable fee established by the agency, plus a dispensing
6 fee. The agency is directed to implement a variable dispensing
7 fee for payments for prescribed medicines while ensuring
8 continued access for Medicaid recipients. The variable
9 dispensing fee may be based upon, but not limited to, either
10 or both the volume of prescriptions dispensed by a specific
11 pharmacy provider and the volume of prescriptions dispensed to
12 an individual recipient. The agency is authorized to limit
13 reimbursement for prescribed medicine in order to comply with
14 any limitations or directions provided for in the General
15 Appropriations Act, which may include implementing a
16 prospective or concurrent utilization review program.
17 (15) A provider of primary care case management
18 services rendered pursuant to a federally approved waiver
19 shall be reimbursed by payment of a fixed, prepaid monthly sum
20 for each Medicaid recipient enrolled with the provider.
21 (16) A provider of rural health clinic services and
22 federally qualified health center services shall be reimbursed
23 a rate per visit based on total reasonable costs of the
24 clinic, as determined by the agency in accordance with federal
25 regulations.
26 (17) A provider of targeted case management services
27 shall be reimbursed pursuant to an established fee, except
28 where the Federal Government requires a public provider be
29 reimbursed on the basis of average actual costs.
30 (18) Unless otherwise provided for in the General
31 Appropriations Act, a provider of transportation services

1 shall be reimbursed the lesser of the amount billed by the
2 provider or the Medicaid maximum allowable fee established by
3 the agency, except when the agency has entered into a direct
4 contract with the provider, or with a community transportation
5 coordinator, for the provision of an all-inclusive service, or
6 when services are provided pursuant to an agreement negotiated
7 between the agency and the provider. The agency, as provided
8 for in s. 427.0135, shall purchase transportation services
9 through the community coordinated transportation system, if
10 available, unless the agency determines a more cost-effective
11 method for Medicaid clients. Nothing in this subsection shall
12 be construed to limit or preclude the agency from contracting
13 for services using a prepaid capitation rate or from
14 establishing maximum fee schedules, individualized
15 reimbursement policies by provider type, negotiated fees,
16 prior authorization, competitive bidding, increased use of
17 mass transit, or any other mechanism that the agency considers
18 efficient and effective for the purchase of services on behalf
19 of Medicaid clients, including implementing a transportation
20 eligibility process. The agency shall not be required to
21 contract with any community transportation coordinator or
22 transportation operator that has been determined by the
23 agency, the Department of Legal Affairs Medicaid Fraud Control
24 Unit, or any other state or federal agency to have engaged in
25 any abusive or fraudulent billing activities. <u>The agency is</u>
26 <u>authorized to make other changes necessary to secure approval</u>
27 <u>of federal waivers needed to permit federal financing of</u>
28 <u>Medicaid transportation services at the service matching rate</u>
29 <u>rather than the administrative matching rate.</u>
30 (19) County health department services may be
31 reimbursed a rate per visit based on total reasonable costs of

1 the clinic, as determined by the agency in accordance with
2 federal regulations under the authority of 42 C.F.R. s.
3 431.615.
4 (20) A renal dialysis facility that provides dialysis
5 services under s. 409.906(9) must be reimbursed the lesser of
6 the amount billed by the provider, the provider's usual and
7 customary charge, or the maximum allowable fee established by
8 the agency, whichever amount is less.
9 (21) The agency shall reimburse school districts which
10 certify the state match pursuant to ss. 236.0812 and 409.9071
11 for the federal portion of the school district's allowable
12 costs to deliver the services, based on the reimbursement
13 schedule. The school district shall determine the costs for
14 delivering services as authorized in ss. 236.0812 and 409.9071
15 for which the state match will be certified. Reimbursement of
16 school-based providers is contingent on such providers being
17 enrolled as Medicaid providers and meeting the qualifications
18 contained in 42 C.F.R. s. 440.110, unless otherwise waived by
19 the federal Health Care Financing Administration. Speech
20 therapy providers who are certified through the Department of
21 Education pursuant to rule 6A-4.0176, Florida Administrative
22 Code, are eligible for reimbursement for services that are
23 provided on school premises. Any employee of the school
24 district who has been fingerprinted and has received a
25 criminal background check in accordance with Department of
26 Education rules and guidelines shall be exempt from any agency
27 requirements relating to criminal background checks.
28 Elementary, middle, and secondary schools affiliated with
29 Florida universities may separately enroll in the Medicaid
30 certified school match program and may certify local
31 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 6. 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 7. 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

1 Medicaid prescribing providers in the state.
2 Section 8. Subsection (2) of section 409.9116, Florida
3 Statutes, is amended to read:
4 409.9116 Disproportionate share/financial assistance
5 program for rural hospitals.--In addition to the payments made
6 under s. 409.911, the Agency for Health Care Administration
7 shall administer a federally matched disproportionate share
8 program and a state-funded financial assistance program for
9 statutory rural hospitals. The agency shall make
10 disproportionate share payments to statutory rural hospitals
11 that qualify for such payments and financial assistance
12 payments to statutory rural hospitals that do not qualify for
13 disproportionate share payments. The disproportionate share
14 program payments shall be limited by and conform with federal
15 requirements. Funds shall be distributed quarterly in each
16 fiscal year for which an appropriation is made.
17 Notwithstanding the provisions of s. 409.915, counties are
18 exempt from contributing toward the cost of this special
19 reimbursement for hospitals serving a disproportionate share
20 of low-income patients.
21 (2) The agency shall use the following formula for
22 distribution of funds for the disproportionate share/financial
23 assistance program for rural hospitals:
24 (a) The agency shall first determine a preliminary
25 payment amount for each rural hospital by allocating all
26 available state funds using the following formula:
27
28 PDAER = (TAERH x TARH)/STAERH
29
30 Where:
31 PDAER = preliminary distribution amount for each rural

1 hospital.
2 TAERH = total amount earned by each rural hospital.
3 TARH = total amount appropriated or distributed under
4 this section.
5 STAERH = sum of total amount earned by each rural
6 hospital.
7 (b) Federal matching funds for the disproportionate
8 share program shall then be calculated for those hospitals
9 that qualify for disproportionate share in paragraph (a).
10 (c) The state-funds-only payment amount shall then be
11 calculated for each hospital using the following formula:
12
13 SFOER = Maximum value of (1) SFOL - PDAER or (2) 0
14
15 Where:
16 SFOER = state-funds-only payment amount for each rural
17 hospital.
18 SFOL = state-funds-only payment level, which is set at
19 4 percent of TARH.
20
21 In calculating the SFOER, PDAER includes federal matching
22 funds from paragraph (b).
23 (d) The adjusted total amount allocated to the rural
24 disproportionate share program shall then be calculated using
25 the following formula:
26
27 ATARH = (TARH - SSFOER)
28
29 Where:
30 ATARH = adjusted total amount appropriated or
31 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.~~

1 ~~Federal matching funds for the disproportionate share program~~
2 ~~shall then be calculated for those hospitals that qualify for~~
3 ~~disproportionate share payments under this section.~~
4 Section 9. Paragraph (b) of subsection (3),
5 subsections (26), and paragraph (a) of subsection (37) of
6 section 409.912, Florida Statutes, are amended to read:
7 409.912 Cost-effective purchasing of health care.--The
8 agency shall purchase goods and services for Medicaid
9 recipients in the most cost-effective manner consistent with
10 the delivery of quality medical care. The agency shall
11 maximize the use of prepaid per capita and prepaid aggregate
12 fixed-sum basis services when appropriate and other
13 alternative service delivery and reimbursement methodologies,
14 including competitive bidding pursuant to s. 287.057, designed
15 to facilitate the cost-effective purchase of a case-managed
16 continuum of care. The agency shall also require providers to
17 minimize the exposure of recipients to the need for acute
18 inpatient, custodial, and other institutional care and the
19 inappropriate or unnecessary use of high-cost services.
20 (3) The agency may contract with:
21 (b) An entity that <u>provides</u> ~~is providing~~ comprehensive
22 behavioral health care services to certain Medicaid recipients
23 through a capitated, prepaid arrangement pursuant to the
24 federal waiver provided for by s. 409.905(5). Such an entity
25 must be licensed under chapter 624, chapter 636, or chapter
26 641 and must possess the clinical systems and operational
27 competence to manage risk and provide comprehensive behavioral
28 health care to Medicaid recipients. As used in this paragraph,
29 the term "comprehensive behavioral health care services" means
30 covered mental health and substance abuse treatment services
31 that are available to Medicaid recipients. The secretary of

1 the Department of Children and Family Services shall approve
2 provisions of procurements related to children in the
3 department's care or custody prior to enrolling such children
4 in a prepaid behavioral health plan. Any contract awarded
5 under this paragraph must be competitively procured. In
6 developing the behavioral health care prepaid plan procurement
7 document, the agency shall ensure that the procurement
8 document requires the contractor to develop and implement a
9 plan to ensure compliance with s. 394.4574 related to services
10 provided to residents of licensed assisted living facilities
11 that hold a limited mental health license. The agency must
12 ensure that Medicaid recipients have available the choice of
13 at least two managed care plans for their behavioral health
14 care services. The agency may continue to reimburse for
15 substance abuse treatment services on a fee-for-service basis
16 until the agency finds that adequate funds are available for
17 capitated, prepaid arrangements or until the agency determines
18 that a capitated arrangement will not adversely affect the
19 availability of substance abuse treatment services.
20 ~~1. By January 1, 2001, the agency shall modify the~~
21 ~~contracts with the entities providing comprehensive inpatient~~
22 ~~and outpatient mental health care services to Medicaid~~
23 ~~recipients in Hillsborough, Highlands, Hardee, Manatee, and~~
24 ~~Polk Counties, to include substance-abuse-treatment services.~~
25 ~~2. By December 31, 2001, the agency shall contract~~
26 ~~with entities providing comprehensive behavioral health care~~
27 ~~services to Medicaid recipients through capitated, prepaid~~
28 ~~arrangements in Charlotte, Collier, DeSoto, Escambia, Glades,~~
29 ~~Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota,~~
30 ~~and Walton Counties. The agency may contract with entities~~
31 ~~providing comprehensive behavioral health care services to~~

1 ~~Medicaid recipients through capitated, prepaid arrangements in~~
2 ~~Alachua County. The agency may determine if Sarasota County~~
3 ~~shall be included as a separate catchment area or included in~~
4 ~~any other agency geographic area.~~
5 1.~~3.~~ Children residing in a Department of Juvenile
6 Justice residential program approved as a Medicaid behavioral
7 health overlay services provider shall not be included in a
8 behavioral health care prepaid health plan pursuant to this
9 paragraph.
10 2.~~4.~~ In converting to a prepaid system of delivery,
11 the agency shall in its procurement document require an entity
12 providing comprehensive behavioral health care services to
13 prevent the displacement of indigent care patients by
14 enrollees in the Medicaid prepaid health plan ~~providing~~
15 ~~behavioral health care services~~ from facilities receiving
16 state funding to provide indigent behavioral health care, to
17 facilities ~~licensed under chapter 395~~ which do not receive
18 state funding for indigent behavioral health care, or
19 reimburse the unsubsidized facility for the cost of behavioral
20 health care provided to the displaced indigent care patient.
21 3.~~5.~~ Traditional community mental health providers
22 under contract with the Department of Children and Family
23 Services pursuant to part IV of chapter 394 and inpatient
24 mental health providers licensed pursuant to chapter 395 must
25 be offered an opportunity to accept or decline a contract to
26 participate in any provider network for prepaid behavioral
27 health services.
28 (26) The agency shall conduct ~~perform choice~~
29 ~~counseling,~~enrollments~~,~~and disenrollments for ~~Medicaid~~
30 ~~recipients who are eligible for~~ MediPass or managed care
31 plans. Notwithstanding the prohibition contained in paragraph

1 (18)(f), managed care plans may perform preenrollments of
2 Medicaid recipients under the supervision of the agency or its
3 agents. For the purposes of this section, "preenrollment"
4 means the provision of marketing and educational materials to
5 a Medicaid recipient and assistance in completing the
6 application forms, but shall not include actual enrollment
7 into a managed care plan. An application for enrollment shall
8 not be deemed complete until the agency or its agent verifies
9 that the recipient made an informed, voluntary choice. ~~The~~
10 ~~agency, in cooperation with the Department of Children and~~
11 ~~Family Services, may test new marketing initiatives to inform~~
12 ~~Medicaid recipients about their managed care options at~~
13 ~~selected sites. The agency shall report to the Legislature on~~
14 ~~the effectiveness of such initiatives.~~ The agency may
15 contract with a third party to perform managed care plan and
16 MediPass ~~choice-counseling,~~enrollment~~,~~and disenrollment
17 services for Medicaid recipients and is authorized to adopt
18 rules to implement such services. ~~The agency may adjust the~~
19 ~~capitation rate only to cover the costs of a third-party~~
20 ~~choice-counseling, enrollment, and disenrollment contract, and~~
21 ~~for agency supervision and management of the managed care plan~~
22 ~~choice-counseling, enrollment, and disenrollment contract.~~
23 (37)(a) The agency shall implement a Medicaid
24 prescribed-drug spending-control program that includes the
25 following components:
26 1. Medicaid prescribed-drug coverage for brand-name
27 drugs for adult Medicaid recipients not residing in nursing
28 homes or other institutions is limited to the dispensing of
29 four brand-name drugs per month per recipient. Children and
30 institutionalized adults are exempt from this restriction.
31 Antiretroviral agents are excluded from this limitation. No

1 requirements for prior authorization or other restrictions on
2 medications used to treat mental illnesses such as
3 schizophrenia, severe depression, or bipolar disorder may be
4 imposed on Medicaid recipients. Medications that will be
5 available without restriction for persons with mental
6 illnesses include atypical antipsychotic medications,
7 conventional antipsychotic medications, selective serotonin
8 reuptake inhibitors, and other medications used for the
9 treatment of serious mental illnesses. The agency shall also
10 limit the amount of a prescribed drug dispensed to no more
11 than a 34-day supply. The agency shall continue to provide
12 unlimited generic drugs, contraceptive drugs and items, and
13 diabetic supplies. The agency may authorize exceptions to the
14 brand-name-drug restriction or to the restricted drug
15 formulary, based upon the treatment needs of the patients,
16 only when such exceptions are based on prior consultation
17 provided by the agency or an agency contractor, but the agency
18 must establish procedures to ensure that:
19 a. There will be a response to a request for prior
20 consultation by telephone or other telecommunication device
21 within 24 hours after receipt of a request for prior
22 consultation; and
23 b. A 72-hour supply of the drug prescribed will be
24 provided in an emergency or when the agency does not provide a
25 response within 24 hours as required by sub-subparagraph a.
26 2. Reimbursement to pharmacies for Medicaid prescribed
27 drugs shall be set at the lowest of the average wholesale
28 price less 13.25 percent, the wholesaler acquisition cost plus
29 7 percent, the federal or state pricing limit, or the
30 provider's usual and customary charge.
31 3. The agency shall develop and implement a process

1 for managing the drug therapies of Medicaid recipients who are
2 using significant numbers of prescribed drugs each month. The
3 management process may include, but is not limited to,
4 comprehensive, physician-directed medical-record reviews,
5 claims analyses, and case evaluations to determine the medical
6 necessity and appropriateness of a patient's treatment plan
7 and drug therapies. The agency may contract with a private
8 organization to provide drug-program-management services.
9 4. The agency may limit the size of its pharmacy
10 network based on need, competitive bidding, price
11 negotiations, credentialing, or similar criteria. The agency
12 shall give special consideration to rural areas in determining
13 the size and location of pharmacies included in the Medicaid
14 pharmacy network. A pharmacy credentialing process may include
15 criteria such as a pharmacy's full-service status, location,
16 size, patient educational programs, patient consultation,
17 disease-management services, and other characteristics. The
18 agency may impose a moratorium on Medicaid pharmacy enrollment
19 when it is determined that it has a sufficient number of
20 Medicaid-participating providers.
21 5. The agency shall develop and implement a program
22 that requires Medicaid practitioners who prescribe drugs to
23 use a counterfeit-proof prescription pad for Medicaid
24 prescriptions. The agency shall require the use of
25 standardized counterfeit-proof prescription pads by
26 Medicaid-participating prescribers or prescribers who write
27 prescriptions for Medicaid recipients. The agency may
28 implement the program in targeted geographic areas or
29 statewide.
30 6. The agency may enter into arrangements that require
31 manufacturers of generic drugs prescribed to Medicaid

1 recipients to provide rebates of at least 15.1 percent of the
2 average manufacturer price for the manufacturer's generic
3 products. These arrangements shall require that if a
4 generic-drug manufacturer pays federal rebates for
5 Medicaid-reimbursed drugs at a level below 15.1 percent, the
6 manufacturer must provide a supplemental rebate to the state
7 in an amount necessary to achieve a 15.1-percent rebate level.
8 If a generic-drug manufacturer raises its price in excess of
9 the Consumer Price Index (Urban), the excess amount shall be
10 included in the supplemental rebate to the state.
11 7. The agency may establish a restricted drug
12 formulary in accordance with 42 U.S.C. s. 1396r and, pursuant
13 to the establishment of such formulary, is authorized to
14 negotiate supplemental rebates from manufacturers at no less
15 than 10 percent of the average wholesale price on the last day
16 of each quarter. State supplemental manufacturer rebates shall
17 be invoiced concurrently with federal rebates.
18 Section 10. Paragraph (a) of subsection (1) and
19 subsection (7) of section 409.915, Florida Statutes, are
20 amended to read:
21 409.915 County contributions to Medicaid.--Although
22 the state is responsible for the full portion of the state
23 share of the matching funds required for the Medicaid program,
24 in order to acquire a certain portion of these funds, the
25 state shall charge the counties for certain items of care and
26 service as provided in this section.
27 (1) Each county shall participate in the following
28 items of care and service:
29 (a) Payments for inpatient hospitalization in excess
30 of 10 ~~12~~ days, but not in excess of 45 days, with the
31 exception of pregnant women and children whose income is in

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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 11. 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.~~

1 Section 12. The Legislature determines and declares
2 that this act fulfills an important state interest.
3 Section 13. This act shall take effect July 1, 2001.
4
5
6 =============== T I T L E   A M E N D M E N T ===============
7 And the title is amended as follows:
8 On page ,
9 remove from the title of the bill:
10
11 and insert in lieu thereof:
12 A bill to be entitled
13 An act relating to the Agency for Health Care
14 Administration; amending s. 409.8132, F.S.;
15 deleting the requirement to provide choice
16 counseling to eligible applicants under the
17 Medikids program component; amending s.
18 409.904, F.S.; authorizing payment for health
19 insurance premiums of Medicaid-eligible
20 individuals under certain circumstances;
21 amending s. 409.905, F.S.; updating and
22 revising provisions relating to hospital
23 inpatient behavioral health services provided
24 pursuant to federally approved waiver;
25 expanding provision of such services statewide;
26 amending s. 490.906, F.S.; providing additional
27 requirements for authorized intermediate care
28 services; adding assistive care services as an
29 optional Medicaid service for certain
30 recipients; amending s. 409.908, F.S.;
31 providing for reimbursement of hospital

1 inpatient and outpatient services at certain
2 rates; deleting redundant provisions;
3 prohibiting increases in reimbursement rates to
4 nursing homes associated with changes in
5 ownership; precluding premium adjustments to
6 managed care organizations under certain
7 circumstances; revising provisions relating to
8 physician reimbursement and the reimbursement
9 fee schedule; deleting certain preferential
10 Medicaid payments for dually eligible
11 recipients; authorizing the securing through
12 waivers of federal financing of transportation
13 services at certain rates; authorizing public
14 schools affiliated with Florida universities to
15 separately enroll in the Medicaid certified
16 school match program and certify local
17 expenditures; amending s. 409.911, F.S.;
18 updating data requirements and share rates for
19 disproportionate share distributions; amending
20 s. 409.91195, F.S.; revising provisions
21 relating to the membership of the Medicaid
22 Pharmaceutical and Therapeutics Committee;
23 providing for development and distribution of a
24 restricted drug formulary for Medicaid
25 providers; amending s. 409.9116, F.S.;
26 modifying the formula for disproportionate
27 share/financial assistance distributions to
28 rural hospitals; amending s. 409.912, F.S.;
29 authorizing continued reimbursement of
30 substance abuse treatment services on a
31 fee-for-service basis under certain conditions;

1 expanding Medicaid managed care behavioral
2 health services statewide; deleting requirement
3 for choice counseling; deleting authorization
4 to test new marketing initiatives relating to
5 managed care options; deleting a restriction on
6 adjustment of capitation rates; modifying
7 reimbursement to pharmacies; permitting use of
8 a restricted drug formulary, authorizing
9 exemptions therefrom, and authorizing
10 negotiation of supplemental rebates from
11 manufacturers pursuant thereto; requiring
12 prescriptions for Medicaid recipients to be on
13 certain standardized forms; amending s.
14 409.915, F.S.; increasing county contributions
15 to Medicaid for inpatient hospitalization;
16 exempting counties from contributing toward the
17 cost of inpatient services provided by certain
18 hospitals and for special Medicaid payments
19 under certain conditions; repealing s.
20 636.0145, F.S., relating to requirement for
21 licensure of certain entities contracting with
22 Medicaid to provide mental health care services
23 in certain counties pursuant to federal waiver,
24 to conform to changes made in this act;
25 providing a finding of important state
26 interest; providing an effective date.
27
28
29
30
31