1
2 An act relating to Medicaid services; amending
3 s. 409.905, F.S.; providing that the Agency for
4 Health Care Administration may restrict the
5 provision of mandatory services by mobile
6 providers; amending s. 409.906, F.S.; providing
7 that the agency may restrict or prohibit the
8 provision of services by mobile providers;
9 providing that Medicaid will not provide
10 reimbursement for dental services provided in
11 mobile dental units, except for certain units;
12 providing an effective date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Section 409.905, Florida Statutes, is
17 amended to read:
18 409.905 Mandatory Medicaid services.--The agency may
19 make payments for the following services, which are required
20 of the state by Title XIX of the Social Security Act,
21 furnished by Medicaid providers to recipients who are
22 determined to be eligible on the dates on which the services
23 were provided. Any service under this section shall be
24 provided only when medically necessary and in accordance with
25 state and federal law. Mandatory services rendered by
26 providers in mobile units to Medicaid recipients may be
27 restricted by the agency. Nothing in this section shall be
28 construed to prevent or limit the agency from adjusting fees,
29 reimbursement rates, lengths of stay, number of visits, number
30 of services, or any other adjustments necessary to comply with
31

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 the availability of moneys and any limitations or directions
2 provided for in the General Appropriations Act or chapter 216.
3 (1) ADVANCED REGISTERED NURSE PRACTITIONER
4 SERVICES.--The agency shall pay for services provided to a
5 recipient by a licensed advanced registered nurse practitioner
6 who has a valid collaboration agreement with a licensed
7 physician on file with the Department of Health or who
8 provides anesthesia services in accordance with established
9 protocol required by state law and approved by the medical
10 staff of the facility in which the anesthetic service is
11 performed. Reimbursement for such services must be provided in
12 an amount that equals not less than 80 percent of the
13 reimbursement to a physician who provides the same services,
14 unless otherwise provided for in the General Appropriations
15 Act.
16 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND
17 TREATMENT SERVICES.--The agency shall pay for early and
18 periodic screening and diagnosis of a recipient under age 21
19 to ascertain physical and mental problems and conditions and
20 provide treatment to correct or ameliorate these problems and
21 conditions. These services include all services determined by
22 the agency to be medically necessary for the treatment,
23 correction, or amelioration of these problems, including
24 personal care, private duty nursing, durable medical
25 equipment, physical therapy, occupational therapy, speech
26 therapy, respiratory therapy, and immunizations.
27 (3) FAMILY PLANNING SERVICES.--The agency shall pay
28 for services necessary to enable a recipient voluntarily to
29 plan family size or to space children. These services include
30 information; education; counseling regarding the availability,
31 benefits, and risks of each method of pregnancy prevention;

1 drugs and supplies; and necessary medical care and followup.
2 Each recipient participating in the family planning portion of
3 the Medicaid program must be provided freedom to choose any
4 alternative method of family planning, as required by federal
5 law.
6 (4) HOME HEALTH CARE SERVICES.--The agency shall pay
7 for nursing and home health aide services, supplies,
8 appliances, and durable medical equipment, necessary to assist
9 a recipient living at home. An entity that provides services
10 pursuant to this subsection shall be licensed under part IV of
11 chapter 400 or part II of chapter 499, if appropriate. These
12 services, equipment, and supplies, or reimbursement therefor,
13 may be limited as provided in the General Appropriations Act
14 and do not include services, equipment, or supplies provided
15 to a person residing in a hospital or nursing facility. In
16 providing home health care services, the agency may require
17 prior authorization of care based on diagnosis.
18 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay
19 for all covered services provided for the medical care and
20 treatment of a recipient who is admitted as an inpatient by a
21 licensed physician or dentist to a hospital licensed under
22 part I of chapter 395. However, the agency shall limit the
23 payment for inpatient hospital services for a Medicaid
24 recipient 21 years of age or older to 45 days or the number of
25 days necessary to comply with the General Appropriations Act.
26 (a) The agency is authorized to implement
27 reimbursement and utilization management reforms in order to
28 comply with any limitations or directions in the General
29 Appropriations Act, which may include, but are not limited to:
30 prior authorization for inpatient psychiatric days; enhanced
31 utilization and concurrent review programs for highly utilized

1 services; reduction or elimination of covered days of service;
2 adjusting reimbursement ceilings for variable costs; adjusting
3 reimbursement ceilings for fixed and property costs; and
4 implementing target rates of increase.
5 (b) A licensed hospital maintained primarily for the
6 care and treatment of patients having mental disorders or
7 mental diseases is not eligible to participate in the hospital
8 inpatient portion of the Medicaid program except as provided
9 in federal law. However, the department shall apply for a
10 waiver, within 9 months after June 5, 1991, designed to
11 provide hospitalization services for mental health reasons to
12 children and adults in the most cost-effective and lowest cost
13 setting possible. Such waiver shall include a request for the
14 opportunity to pay for care in hospitals known under federal
15 law as "institutions for mental disease" or "IMD's." The
16 waiver proposal shall propose no additional aggregate cost to
17 the state or Federal Government, and shall be conducted in
18 Hillsborough County, Highlands County, Hardee County, Manatee
19 County, and Polk County. The waiver proposal may incorporate
20 competitive bidding for hospital services, comprehensive
21 brokering, prepaid capitated arrangements, or other mechanisms
22 deemed by the department to show promise in reducing the cost
23 of acute care and increasing the effectiveness of preventive
24 care. When developing the waiver proposal, the department
25 shall take into account price, quality, accessibility,
26 linkages of the hospital to community services and family
27 support programs, plans of the hospital to ensure the earliest
28 discharge possible, and the comprehensiveness of the mental
29 health and other health care services offered by participating
30 providers.
31

1 (c) Agency for Health Care Administration shall adjust
2 a hospital's current inpatient per diem rate to reflect the
3 cost of serving the Medicaid population at that institution
4 if:
5 1. The hospital experiences an increase in Medicaid
6 caseload by more than 25 percent in any year, primarily
7 resulting from the closure of a hospital in the same service
8 area occurring after July 1, 1995; or
9 2. The hospital's Medicaid per diem rate is at least
10 25 percent below the Medicaid per patient cost for that year.
11
12 No later than November 1, 2000, the agency must provide
13 estimated costs for any adjustment in a hospital inpatient per
14 diem pursuant to this paragraph to the Executive Office of the
15 Governor, the House of Representatives General Appropriations
16 Committee, and the Senate Budget Committee. Before the agency
17 implements a change in a hospital's inpatient per diem rate
18 pursuant to this paragraph, the Legislature must have
19 specifically appropriated sufficient funds in the 2001-2002
20 General Appropriations Act to support the increase in cost as
21 estimated by the agency. This paragraph is repealed on July 1,
22 2001.
23 (6) HOSPITAL OUTPATIENT SERVICES.--The agency shall
24 pay for preventive, diagnostic, therapeutic, or palliative
25 care and other services provided to a recipient in the
26 outpatient portion of a hospital licensed under part I of
27 chapter 395, and provided under the direction of a licensed
28 physician or licensed dentist, except that payment for such
29 care and services is limited to $1,500 per state fiscal year
30 per recipient, unless an exception has been made by the
31 agency, and with the exception of a Medicaid recipient under

1 age 21, in which case the only limitation is medical
2 necessity.
3 (7) INDEPENDENT LABORATORY SERVICES.--The agency shall
4 pay for medically necessary diagnostic laboratory procedures
5 ordered by a licensed physician or other licensed practitioner
6 of the healing arts which are provided for a recipient in a
7 laboratory that meets the requirements for Medicare
8 participation and is licensed under chapter 483, if required.
9 (8) NURSING FACILITY SERVICES.--The agency shall pay
10 for 24-hour-a-day nursing and rehabilitative services for a
11 recipient in a nursing facility licensed under part II of
12 chapter 400 or in a rural hospital, as defined in s. 395.602,
13 or in a Medicare certified skilled nursing facility operated
14 by a hospital, as defined by s. 395.002(11), that is licensed
15 under part I of chapter 395, and in accordance with provisions
16 set forth in s. 409.908(2)(a), which services are ordered by
17 and provided under the direction of a licensed physician.
18 However, if a nursing facility has been destroyed or otherwise
19 made uninhabitable by natural disaster or other emergency and
20 another nursing facility is not available, the agency must pay
21 for similar services temporarily in a hospital licensed under
22 part I of chapter 395 provided federal funding is approved and
23 available.
24 (9) PHYSICIAN SERVICES.--The agency shall pay for
25 covered services and procedures rendered to a recipient by, or
26 under the personal supervision of, a person licensed under
27 state law to practice medicine or osteopathic medicine. These
28 services may be furnished in the physician's office, the
29 Medicaid recipient's home, a hospital, a nursing facility, or
30 elsewhere, but shall be medically necessary for the treatment
31 of an injury, illness, or disease within the scope of the

practice of medicine or osteopathic medicine as defined by state law. The agency shall not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.

(10) PORTABLE X-RAY SERVICES.--The agency shall pay for professional and technical portable radiological services ordered by a licensed physician or other licensed practitioner of the healing arts which are provided by a licensed professional in a setting other than a hospital, clinic, or office of a physician or practitioner of the healing arts, on behalf of a recipient.

(11) RURAL HEALTH CLINIC SERVICES.--The agency shall pay for outpatient primary health care services for a recipient provided by a clinic certified by and participating in the Medicare program which is located in a federally designated, rural, medically underserved area and has on its staff one or more licensed primary care nurse practitioners or physician assistants, and a licensed staff supervising physician or a consulting supervising physician.

(12) TRANSPORTATION SERVICES.--The agency shall ensure that appropriate transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for medically necessary and Medicaid-compensable services, provided a client's ability to choose a specific transportation provider shall be limited to those options resulting from policies established by the agency to meet the fiscal limitations of the General Appropriations Act. The agency may pay for transportation and other related travel expenses as necessary only if these services are not otherwise available.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 Section 2. Section 409.906, Florida Statutes, is
2 amended to read:
3 409.906 Optional Medicaid services.--Subject to
4 specific appropriations, the agency may make payments for
5 services which are optional to the state under Title XIX of
6 the Social Security Act and are furnished by Medicaid
7 providers to recipients who are determined to be eligible on
8 the dates on which the services were provided. Any optional
9 service that is provided shall be provided only when medically
10 necessary and in accordance with state and federal law.
11 Optional services rendered by providers in mobile units to
12 Medicaid recipients may be restricted or prohibited by the
13 agency. Nothing in this section shall be construed to prevent
14 or limit the agency from adjusting fees, reimbursement rates,
15 lengths of stay, number of visits, or number of services, or
16 making any other adjustments necessary to comply with the
17 availability of moneys and any limitations or directions
18 provided for in the General Appropriations Act or chapter 216.
19 If necessary to safeguard the state's systems of providing
20 services to elderly and disabled persons and subject to the
21 notice and review provisions of s. 216.177, the Governor may
22 direct the Agency for Health Care Administration to amend the
23 Medicaid state plan to delete the optional Medicaid service
24 known as "Intermediate Care Facilities for the Developmentally
25 Disabled." Optional services may include:
26 (1) ADULT DENTURE SERVICES.--The agency may pay for
27 dentures, the procedures required to seat dentures, and the
28 repair and reline of dentures, provided by or under the
29 direction of a licensed dentist, for a recipient who is age 21
30 or older. However, Medicaid will not provide reimbursement for
31

1 dental services provided in a mobile dental unit, except for a
2 mobile dental unit:
3 (a) Owned by, operated by, or having a contractual
4 agreement with the Department of Health and complying with
5 Medicaid's county health department clinic services program
6 specifications as a county health department clinic services
7 provider.
8 (b) Owned by, operated by, or having a contractual
9 arrangement with a federally qualified health center and
10 complying with Medicaid's federally qualified health center
11 specifications as a federally qualified health center
12 provider.
13 (c) Rendering dental services to Medicaid recipients,
14 21 years of age and older, at nursing facilities.
15 (d) Owned by, operated by, or having a contractual
16 agreement with a state-approved dental educational
17 institution.
18 (2) ADULT HEALTH SCREENING SERVICES.--The agency may
19 pay for an annual routine physical examination, conducted by
20 or under the direction of a licensed physician, for a
21 recipient age 21 or older, without regard to medical
22 necessity, in order to detect and prevent disease, disability,
23 or other health condition or its progression.
24 (3) AMBULATORY SURGICAL CENTER SERVICES.--The agency
25 may pay for services provided to a recipient in an ambulatory
26 surgical center licensed under part I of chapter 395, by or
27 under the direction of a licensed physician or dentist.
28 (4) BIRTH CENTER SERVICES.--The agency may pay for
29 examinations and delivery, recovery, and newborn assessment,
30 and related services, provided in a licensed birth center
31 staffed with licensed physicians, certified nurse midwives,

1 and midwives licensed in accordance with chapter 467, to a
2 recipient expected to experience a low-risk pregnancy and
3 delivery.
4 (5) CASE MANAGEMENT SERVICES.--The agency may pay for
5 primary care case management services rendered to a recipient
6 pursuant to a federally approved waiver, and targeted case
7 management services for specific groups of targeted
8 recipients, for which funding has been provided and which are
9 rendered pursuant to federal guidelines. The agency is
10 authorized to limit reimbursement for targeted case management
11 services in order to comply with any limitations or directions
12 provided for in the General Appropriations Act.
13 Notwithstanding s. 216.292, the Department of Children and
14 Family Services may transfer general funds to the Agency for
15 Health Care Administration to fund state match requirements
16 exceeding the amount specified in the General Appropriations
17 Act for targeted case management services.
18 (6) CHILDREN'S DENTAL SERVICES.--The agency may pay
19 for diagnostic, preventive, or corrective procedures,
20 including orthodontia in severe cases, provided to a recipient
21 under age 21, by or under the supervision of a licensed
22 dentist. Services provided under this program include
23 treatment of the teeth and associated structures of the oral
24 cavity, as well as treatment of disease, injury, or impairment
25 that may affect the oral or general health of the individual.
26 However, Medicaid will not provide reimbursement for dental
27 services provided in a mobile dental unit, except for a mobile
28 dental unit:
29 (a) Owned by, operated by, or having a contractual
30 agreement with the Department of Health and complying with
31 Medicaid's county health department clinic services program

CODING:Words ~~stricken~~ are deletions; words underlined are additions.

1 specifications as a county health department clinic services
2 provider.
3 (b) Owned by, operated by, or having a contractual
4 arrangement with a federally qualified health center and
5 complying with Medicaid's federally qualified health center
6 specifications as a federally qualified health center
7 provider.
8 (c) Rendering dental services to Medicaid recipients,
9 21 years of age and older, at nursing facilities.
10 (d) Owned by, operated by, or having a contractual
11 agreement with a state-approved dental educational
12 institution.
13 (7) CHIROPRACTIC SERVICES.--The agency may pay for
14 manual manipulation of the spine and initial services,
15 screening, and X rays provided to a recipient by a licensed
16 chiropractic physician.
17 (8) COMMUNITY MENTAL HEALTH SERVICES.--The agency may
18 pay for rehabilitative services provided to a recipient by a
19 mental health or substance abuse provider licensed by the
20 agency and under contract with the agency or the Department of
21 Children and Family Services to provide such services. Those
22 services which are psychiatric in nature shall be rendered or
23 recommended by a psychiatrist, and those services which are
24 medical in nature shall be rendered or recommended by a
25 physician or psychiatrist. The agency must develop a provider
26 enrollment process for community mental health providers which
27 bases provider enrollment on an assessment of service need.
28 The provider enrollment process shall be designed to control
29 costs, prevent fraud and abuse, consider provider expertise
30 and capacity, and assess provider success in managing
31 utilization of care and measuring treatment outcomes.

1 Providers will be selected through a competitive procurement
2 or selective contracting process. In addition to other
3 community mental health providers, the agency shall consider
4 for enrollment mental health programs licensed under chapter
5 395 and group practices licensed under chapter 458, chapter
6 459, chapter 490, or chapter 491. The agency is also
7 authorized to continue operation of its behavioral health
8 utilization management program and may develop new services if
9 these actions are necessary to ensure savings from the
10 implementation of the utilization management system. The
11 agency shall coordinate the implementation of this enrollment
12 process with the Department of Children and Family Services
13 and the Department of Juvenile Justice. The agency is
14 authorized to utilize diagnostic criteria in setting
15 reimbursement rates, to preauthorize certain high-cost or
16 highly utilized services, to limit or eliminate coverage for
17 certain services, or to make any other adjustments necessary
18 to comply with any limitations or directions provided for in
19 the General Appropriations Act.
20 (9) DIALYSIS FACILITY SERVICES.--Subject to specific
21 appropriations being provided for this purpose, the agency may
22 pay a dialysis facility that is approved as a dialysis
23 facility in accordance with Title XVIII of the Social Security
24 Act, for dialysis services that are provided to a Medicaid
25 recipient under the direction of a physician licensed to
26 practice medicine or osteopathic medicine in this state,
27 including dialysis services provided in the recipient's home
28 by a hospital-based or freestanding dialysis facility.
29 (10) DURABLE MEDICAL EQUIPMENT.--The agency may
30 authorize and pay for certain durable medical equipment and
31

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 supplies provided to a Medicaid recipient as medically
2 necessary.
3 (11) HEALTHY START SERVICES.--The agency may pay for a
4 continuum of risk-appropriate medical and psychosocial
5 services for the Healthy Start program in accordance with a
6 federal waiver. The agency may not implement the federal
7 waiver unless the waiver permits the state to limit enrollment
8 or the amount, duration, and scope of services to ensure that
9 expenditures will not exceed funds appropriated by the
10 Legislature or available from local sources. If the Health
11 Care Financing Administration does not approve a federal
12 waiver for Healthy Start services, the agency, in consultation
13 with the Department of Health and the Florida Association of
14 Healthy Start Coalitions, is authorized to establish a
15 Medicaid certified-match program for Healthy Start services.
16 Participation in the Healthy Start certified-match program
17 shall be voluntary, and reimbursement shall be limited to the
18 federal Medicaid share to Medicaid-enrolled Healthy Start
19 coalitions for services provided to Medicaid recipients. The
20 agency shall take no action to implement a certified-match
21 program without ensuring that the amendment and review
22 requirements of ss. 216.177 and 216.181 have been met.
23 (12) HEARING SERVICES.--The agency may pay for hearing
24 and related services, including hearing evaluations, hearing
25 aid devices, dispensing of the hearing aid, and related
26 repairs, if provided to a recipient by a licensed hearing aid
27 specialist, otolaryngologist, otologist, audiologist, or
28 physician.
29 (13) HOME AND COMMUNITY-BASED SERVICES.--The agency
30 may pay for home-based or community-based services that are
31

rendered to a recipient in accordance with a federally approved waiver program.

(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.

(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.

(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.

(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.

(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.

1 (19) PODIATRIC SERVICES.--The agency may pay for
2 services, including diagnosis and medical, surgical,
3 palliative, and mechanical treatment, related to ailments of
4 the human foot and lower leg, if provided to a recipient by a
5 podiatric physician licensed under state law.
6 (20) PRESCRIBED DRUG SERVICES.--The agency may pay for
7 medications that are prescribed for a recipient by a physician
8 or other licensed practitioner of the healing arts authorized
9 to prescribe medications and that are dispensed to the
10 recipient by a licensed pharmacist or physician in accordance
11 with applicable state and federal law.
12 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.--The
13 agency may pay for all services provided to a recipient by a
14 registered nurse first assistant as described in s. 464.027.
15 Reimbursement for such services may not be less than 80
16 percent of the reimbursement that would be paid to a physician
17 providing the same services.
18 (22) STATE HOSPITAL SERVICES.--The agency may pay for
19 all-inclusive psychiatric inpatient hospital care provided to
20 a recipient age 65 or older in a state mental hospital.
21 (23) VISUAL SERVICES.--The agency may pay for visual
22 examinations, eyeglasses, and eyeglass repairs for a
23 recipient, if they are prescribed by a licensed physician
24 specializing in diseases of the eye or by a licensed
25 optometrist.
26 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.--The
27 Agency for Health Care Administration, in consultation with
28 the Department of Children and Family Services, may establish
29 a targeted case-management pilot project in those counties
30 identified by the Department of Children and Family Services
31 and for the community-based child welfare project in Sarasota

1 and Manatee counties, as authorized under s. 409.1671. These
2 projects shall be established for the purpose of determining
3 the impact of targeted case management on the child welfare
4 program and the earnings from the child welfare program.
5 Results of the pilot projects shall be reported to the Child
6 Welfare Estimating Conference and the Social Services
7 Estimating Conference established under s. 216.136. The number
8 of projects may not be increased until requested by the
9 Department of Children and Family Services, recommended by the
10 Child Welfare Estimating Conference and the Social Services
11 Estimating Conference, and approved by the Legislature. The
12 covered group of individuals who are eligible to receive
13 targeted case management include children who are eligible for
14 Medicaid; who are between the ages of birth through 21; and
15 who are under protective supervision or postplacement
16 supervision, under foster-care supervision, or in shelter care
17 or foster care. The number of individuals who are eligible to
18 receive targeted case management shall be limited to the
19 number for whom the Department of Children and Family Services
20 has available matching funds to cover the costs. The general
21 revenue funds required to match the funds for services
22 provided by the community-based child welfare projects are
23 limited to funds available for services described under s.
24 409.1671. The Department of Children and Family Services may
25 transfer the general revenue matching funds as billed by the
26 Agency for Health Care Administration.
27 Section 3. This act shall take effect July 1, 2001.
28
29
30
31

CODING: Words ~~stricken~~ are deletions; words underlined are additions.