By the Committee on Health, Aging and Long-Term Care; and Senator Silver

309-1680A-01

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 409.904, F.S.; revising eligibility requirements for certain medical assistance payments; providing for the agency to pay for health insurance premiums for certain Medicaid-eligible persons; providing for the agency to pay for specified cancer treatment; amending s. 409.905, F.S.; prescribing conditions upon which an adjustment in a hospital's inpatient per diem rate may be based; prescribing additional limitations that may be placed on hospital inpatient services under Medicaid; amending s. 409.906, F.S.; providing for reimbursement and use-management reforms with respect to community mental health services; revising standards for payable intermediate care services; amending s. 409.908, F.S.; revising standards, guidelines, and limitations relating to reimbursement of Medicaid providers; amending s. 409.911, F.S.; updating data requirements and share rates for disproportionate share distributions; amending s. 409.9116, F.S.; modifying the formula for disproportionate share/financial assistance distribution to rural hospitals; amending s. 409.91195, F.S.; providing for a restricted-drug formulary applicable to Medicaid providers; revising membership of the Medicaid Pharmaceutical and Therapeutics Committee; authorizing the agency to negotiate

rebates from drug manufacturers; amending s. 409.912, F.S.; authorizing the agency to contract with children's provider networks for certain purposes; specifying conditions under which the agency may enter certain contracts with exclusive provider organizations; revising components of the agency's spending-control program; prescribing additional services that the agency may provide through competitive bidding; authorizing the agency to establish, and make exceptions to, a restricted-drug formulary; amending s. 409.9122, F.S.; providing for disproportionate assignment of certain Medicaid-eligible children to children's clinic networks; providing for assignment of certain Medicaid recipients to managed-care plans; amending s. 409.913, F.S.; requiring the agency to implement a pilot program to prevent Medicaid fraud and abuse with respect to pharmaceuticals; amending s. 409.915, F.S.; exempting counties from contributing toward the increased cost of hospital inpatient services due to elimination of Medicaid ceilings on certain types of hospitals and for special Medicaid reimbursement to hospitals; revising the level of county participation; providing an effective date.

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

Section 1. Subsection (1) of section 409.904, Florida Statutes, is amended, and subsections (9) and (10) are added to that section, to read:

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

(1) A person who is age 65 or older or is determined to be disabled, whose income is at or below 87.5 ~~100~~ percent of federal poverty level, and whose assets do not exceed established limitations.

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

(10) Eligible women with incomes below 200 percent of the federal poverty level and from ages 50 to 64, for cancer treatment pursuant to the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, screened through the National Breast and Cervical Cancer Early Detection program.

Section 2. Subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be

provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

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

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; <u>prior authorization for nonemergency hospital inpatient admissions; authorization of emergency and urgent-care admissions within 24 hours after admission;</u>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 in federal law. However, the department shall apply for a waiver, within 9 months after June 5, 1991, designed to provide hospitalization services for mental health reasons to children and adults in the most cost-effective and lowest cost setting possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The waiver proposal shall propose no additional aggregate cost to the state or Federal Government, and shall be conducted in Hillsborough County, Highlands County, Hardee County, Manatee County, and Polk County. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to ensure the earliest discharge possible, and the comprehensiveness of the mental health and other health care services offered by participating providers.

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

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

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

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

Section 3. Subsections (8) and (16) of section 409.906, Florida Statutes, are amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing

services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(8) COMMUNITY MENTAL HEALTH SERVICES.--

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

utilization management system. The agency shall coordinate the implementation of this enrollment process with the Department of Children and Family Services and the Department of Juvenile Justice. The agency is authorized to utilize diagnostic criteria in setting reimbursement rates, to preauthorize certain high-cost or highly utilized services, to limit or eliminate coverage for certain services, or to make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(b) The agency is authorized to implement reimbursement and use 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 of treatment and service plans; prior authorization of services; enhanced use review programs for highly used services; and limits on services for those determined to be abusing their benefit coverages.

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

Section 4. Paragraph (a) of subsection (1), paragraph (b) of subsection (2), and subsections (4), (9), (11), (13), (14), and (18) of section 409.908, Florida Statutes, are amended to read:

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

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(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.~~

(2)

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. <u>The agency shall not provide for any increases in reimbursement rates to nursing homes associated</u>

with changes in ownership filed on or after January 1, 2002. Under the plan, interim rate adjustments shall not be granted to reflect increases in the cost of general or professional liability insurance for nursing homes unless the following criteria are met: have at least a 65 percent Medicaid utilization in the most recent cost report submitted to the agency, and the increase in general or professional liability costs to the facility for the most recent policy period affects the total Medicaid per diem by at least 5 percent. This rate adjustment shall not result in the per diem exceeding the class ceiling. ~~This provision shall apply only to fiscal year 2000-2001 and shall be implemented to the extent existing appropriations are available. The agency shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate by December 31, 2000, on the cost of liability insurance for Florida nursing homes for fiscal years 1999 and 2000 and the extent to which these costs are not being compensated by the Medicaid program. Medicaid-participating nursing homes shall be required to report to the agency information necessary to compile this report. Effective no earlier than the rate-setting period beginning April 1, 1999,~~The agency shall establish a case-mix reimbursement methodology for the rate of payment for long-term care services for nursing home residents. The agency shall compute a per diem rate for Medicaid residents, adjusted for case mix, which is based on a resident classification system that accounts for the relative resource utilization by different types of residents and which is based on level-of-care data and other appropriate data. The case-mix methodology developed by the agency shall take into account the medical, behavioral, and cognitive deficits of

residents. In developing the reimbursement methodology, the agency shall evaluate and modify other aspects of the reimbursement plan as necessary to improve the overall effectiveness of the plan with respect to the costs of patient care, operating costs, and property costs. In the event adequate data are not available, the agency is authorized to adjust the patient's care component or the per diem rate to more adequately cover the cost of services provided in the patient's care component. The agency shall work with the Department of Elderly Affairs, the Florida Health Care Association, and the Florida Association of Homes for the Aging in developing the methodology. It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on

claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and, beginning September 1, 1995, shall include age-band differentials in such calculations. Effective July 1, 2001, the cost of exempting statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals from reimbursement ceilings and the cost of special Medicaid payments shall not be included in premiums paid to health maintenance organizations or prepaid health care plans.

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

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

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

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

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

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

beneficiary with respect to an item or service is reduced or eliminated. This expression of the Legislature is in clarification of existing law and shall apply to payment for, and with respect to provider agreements with respect to, items or services furnished on or after the effective date of this act. This paragraph applies to payment by Medicaid for items and services furnished before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of this section, and that is pending as of, or is initiated after, the effective date of this act.

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

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

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

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

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

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

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

(14) A provider of prescribed drugs shall be reimbursed on the basis of competitive bidding or for the

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

(18) Unless otherwise provided for in the General Appropriations Act, a provider of transportation services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency, except when the agency has entered into a direct contract with the provider, or with a community transportation coordinator, for the provision of an all-inclusive service, or when services are provided pursuant to an agreement negotiated between the agency and the provider. The agency, as provided for in s. 427.0135, shall purchase transportation services through the community coordinated transportation system, if available, unless the agency determines a more cost-effective method for Medicaid clients. Nothing in this subsection shall be construed to limit or preclude the agency from contracting for services using a prepaid capitation rate or from establishing maximum fee schedules, individualized reimbursement policies by provider type, negotiated fees,

prior authorization, competitive bidding, increased use of mass transit, or any other mechanism that the agency considers efficient and effective for the purchase of services on behalf of Medicaid clients, including implementing a transportation eligibility process. The agency shall not be required to contract with any community transportation coordinator or transportation operator that has been determined by the agency, the Department of Legal Affairs Medicaid Fraud Control Unit, or any other state or federal agency to have engaged in any abusive or fraudulent billing activities. The agency is authorized to competitively procure transportation services or make other changes necessary to secure approval of federal waivers needed to permit federal financing of Medicaid transportation services at the service matching rate rather than the administrative matching rate.

Section 5. 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 6. Subsection (2) of section 409.9116, Florida Statutes, is amended to read:

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

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

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

PDAER = (TAERH x TARH)/STAERH

Where:

PDAER = preliminary distribution amount for each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section.

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

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

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

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

Where:

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

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

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

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

ATARH = (TARH - SSFOER)

Where:

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

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

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

DAERH = [(TAERH x ATARH)/STAERH]

Where:

DAERH = distribution amount for each rural hospital.

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

(g) State-funds-only payment amounts calculated under paragraph (c) and corresponding federal matching funds are then added to the results of paragraph (f) to determine the total distribution amount for each rural hospital.

~~In determining the payment amount for each rural hospital under this section, the agency shall first allocate all available state funds by the following formula:~~

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

~~Where:~~

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

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

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

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

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

Section 7. Section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.--There is created a Medicaid Pharmaceutical and Therapeutics Committee within the Agency for Health Care Administration for the purpose of developing a restricted-drug formulary under 42 U.S.C. s. 1396r-8. ~~The committee shall develop and implement a voluntary Medicaid preferred prescribed drug designation program. The program shall provide information to Medicaid providers on medically appropriate and cost-efficient prescription drug therapies through the development and publication of a voluntary Medicaid preferred prescribed-drug list.~~

(1) The Medicaid Pharmaceutical and Therapeutics Committee shall be comprised of nine members as specified by 42 U.S.C. s. 1396r-8.~~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. The committee shall comply with rules adopted by the agency.

(2) The Medicaid Pharmaceutical and Therapeutics Committee shall develop a restricted-drug formulary for

recommendation to the agency, and may recommend additions to and deletions from the formulary, such that the formulary provides for medically appropriate drug therapies for Medicaid recipients which achieve cost savings in the Medicaid program. The committee shall recommend for inclusion in the formulary:

(a) Any drug that has a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary, as determined by the committee and as set forth in 42 U.S.C. s. 1396r-8;

(b) Any drug for which the agency has negotiated and accepted a supplemental rebate pursuant to this section; and

(c) Any drug formulary presented to the committee by the agency.~~Upon recommendation by the committee, the Agency for Health Care Administration shall establish 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 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) Upon recommendation by the committee, the agency may establish a restricted-drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, is authorized to negotiate supplemental rebates from manufacturers. The restricted-drug formulary must

be applied to all drugs for which reimbursement is provided by the Medicaid program. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. Supplemental rebates must be invoiced concurrently with federal rebate billing. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a state expenditure. Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, and other services or administrative investments with guaranteed savings to the Medicaid program.

(4) Reimbursement of drugs not included on the formulary shall be subject to prior authorization by the agency.

(5)~~(3)~~ The Agency for Health Care Administration shall publish and disseminate the restricted-drug formulary ~~voluntary Medicaid preferred prescribed drug list~~ to all Medicaid providers in the state.

Section 8. Paragraph (g) is added to subsection (3) of section 409.912, Florida Statutes, and subsections (6), (34), and (37) of that section are amended, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed

to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(3) The agency may contract with:

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

(6) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that ~~the contract does not cost more than a managed care plan contract in the same agency region and that~~ the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law.

(34) The agency may provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, durable medical equipment and supplies, and prescribed drug services through competitive bidding ~~negotiation~~ pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid such ~~home health~~ services. The agency may

exclude providers not selected through the bidding process from the Medicaid provider network.

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

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

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

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

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent or based on competitive bid in those counties with more than 35 Medicaid participating pharmacies.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services.

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

when it is determined that it has a sufficient number of Medicaid-participating providers.

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

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

7. The agency may establish a restricted-drug formulary in accordance with 42 U.S.C. s. 1396r, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers at no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of the quarter unless the federal or supplemental rebate, or both, exceeds 25 percent and the agency determines the product competitive. The agency

may determine that specific generic products are competitive at lower rebate percentages.

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

(c) The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15 of each year. The report must include, but need not be limited to, the progress made in implementing Medicaid cost-containment measures and their effect on Medicaid prescribed-drug expenditures.

Section 9. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans or provider service networks until an equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain an equal enrollment in MediPass and managed care plans ~~for the 1998-1999 fiscal year~~. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based

proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall also disproportionately assign Medicaid-eligible children in families who are required to but have failed to make a choice of managed-care plan or MediPass for their child and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(3)(g) and where available. The disproportionate assignment of children to children's networks shall be made until the agency has determined that the children's networks have sufficient numbers to be economically operated.When making assignments, the agency shall take into account the following criteria:

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

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

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

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

(k)~~1. Notwithstanding the provisions of paragraph (f), and for the 2000-2001 fiscal year only, when a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a~~

~~managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain an equal enrollment in MediPass and managed care plans.~~When making assignments, the agency shall take into account the following criteria:

1.~~a.~~ A managed care plan has sufficient network capacity to meet the need of members.

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

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

4.~~d.~~ The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

5.~~e.~~ The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.

~~2. This paragraph is repealed on July 1, 2001.~~

Section 10. Subsection (26) is added to section 409.913, Florida Statutes, to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

(26)(a) The Agency for Health Care Administration shall develop and implement a pilot program to prevent Medicaid fraud and abuse in Medicaid-participating pharmacies by using a type of automated fingerprint imaging of Medicaid beneficiaries eligible under this chapter.

(b) In adopting rules under this subsection, the agency shall ensure that any automated fingerprint imaging performed by the agency is used only to prevent fraud and abuse of pharmacy benefits by Medicaid beneficiaries and is in compliance with state and federal disclosure requirements.

(c) The agency shall prepare, by October 2001, a plan for implementation of this program. Implementation shall begin with a pilot of the program in one or more areas of the state by April 1, 2002. The agency shall evaluate the pilot program to ensure its cost effectiveness before expanding the program statewide.

(d) The agency shall request any federal waivers necessary to implement the program within the limits described in this subsection.

Section 11. Paragraph (a) of subsection (1) and subsection (7) of section 409.915, Florida Statutes, are amended to read:

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

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

(a) For both health maintenance members and fee-for-service beneficiaries, payments for inpatient hospitalization in excess of 11 ~~12~~ days, but not in excess of 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program.

(7) Counties are exempt from contributing toward the cost of new exemptions on inpatient ceilings for statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals that came into effect July 1, 2000, and for special Medicaid payments that came into effect on or after July 1, 2000. ~~Notwithstanding any provision of this section to the contrary, counties are exempt from contributing toward the increased cost of hospital inpatient services due to the elimination of ceilings on Medicaid inpatient reimbursement rates paid to teaching hospitals, specialty hospitals, and community health education program hospitals and for special Medicaid reimbursements to hospitals for which the Legislature has specifically appropriated funds. This subsection is repealed on July 1, 2001.~~

Section 12. This act shall take effect July 1, 2001.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 792

The Committee Substitute for SB 792 contains the Medicaid-related substantive provisions of the Appropriations Implementing Bill (SB 2002).

The bill reduces the income eligibility level for the elderly and disabled to 87.5 percent of the federal poverty level, makes Medicaid-eligible individuals who are insured eligible for Medicaid for purposes of paying health insurance premiums if the Agency for Health Care Administration (agency or AHCA) determines this to be cost-effective, and makes certain women eligible for cancer treatment. The agency is authorized to require prior authorization for nonemergency hospital inpatient admissions and for emergency and urgent-care admissions within 24 hours after admission. The bill removes the requirement that community mental health or substance abuse providers be licensed by the agency in order to be reimbursed for rehabilitative services. The agency is authorized to implement reimbursement and use management reforms for community mental health services. The bill limits reimbursement for intermediate nursing home services to persons who meet the nursing home level of care criteria as determined by the Department of Elderly Affairs CARES program and excludes reimbursement for services defined as general care in the Medicaid budget estimating process.

The bill deletes an exemption for counties contributing toward the cost of the special exception reimbursement for certain hospitals providing graduate medical education. The agency is prohibited from increasing nursing home reimbursements associated with changes of ownership filed on or after January 1, 2002. The bill specifies that, effective July 1, 2001, the cost of exempting certain hospitals from reimbursement ceilings and the cost of special Medicaid payments are not to be included in premiums paid to HMOs and prepaid health clinics. The bill requires competitive bidding for home health services, medical supplies and appliances, independent laboratory services, and prescribed drugs. The agency is authorized to competitively procure transportation services or make changes to permit federal financing of transportation services at the service matching rate rather than the administrative matching rate. The agency may exclude providers not selected through the competitive bidding process from the Medicaid provider network. The bill deletes the requirement that Medicaid pay deductibles and coinsurance for nursing home and hospital outpatient Medicare part B services.

The bill modifies the formulas for calculating regular hospital disproportionate share payments and rural hospital disproportionate share payments. The Medicaid Pharmaceutical and Therapeutics Committee provisions are revised to conform to federal requirements and to develop a restricted-drug formulary. The agency may authorize exceptions to the restricted-drug formulary. Pursuant to the establishment of a restricted-drug formulary, the agency is authorized to negotiate supplemental rebates from manufacturers. The limit of four brand-name prescription drugs per month is extended to

adult Medicaid recipients in nursing homes or other institutions. Reimbursements to pharmacies may be based on competitive bids in those counties with more than 35 Medicaid participating pharmacies.

The agency is authorized to contract with certain children's provider networks. The agency is required to disproportionately assign Medicaid-eligible children whose families do not select a provider to a children's network until the children's networks have sufficient numbers to be economically operated.

The bill requires the agency to develop and implement a pilot program to prevent Medicaid fraud and abuse in Medicaid-participating pharmacies by using a type of automated fingerprint imaging of Medicaid beneficiaries. The provisions relating to county contributions to Medicaid are revised to require county contributions for all Medicaid beneficiaries for inpatient hospitalization in excess of 11 days, rather than 12 days, but not in excess of 45 days. Counties are exempt from contributing toward certain new exemptions on inpatient ceilings and special Medicaid payments.