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

309-1976A-01

1 A bill to be entitled
2 An act relating to the Agency for Health Care
3 Administration; amending s. 409.904, F.S.;
4 providing for the agency to pay for health
5 insurance premiums for certain
6 Medicaid-eligible persons; providing for the
7 agency to pay for specified cancer treatment;
8 providing Medicaid eligibility for certain
9 disabled persons under a Medicaid buy-in
10 program, subject to specific federal
11 authorization; directing the Agency for Health
12 Care Administration to seek a federal grant,
13 demonstration project, or waiver for
14 establishment of such buy-in program, subject
15 to a specific appropriation; amending s.
16 409.905, F.S.; prescribing conditions upon
17 which an adjustment in a hospital's inpatient
18 per diem rate may be based; prescribing
19 additional limitations that may be placed on
20 hospital inpatient services under Medicaid;
21 amending s. 409.906, F.S.; providing for
22 reimbursement and use-management reforms with
23 respect to community mental health services;
24 revising standards for payable intermediate
25 care services; authorizing the agency to pay
26 for assistive-care services; amending s.
27 409.908, F.S.; revising standards, guidelines,
28 and limitations relating to reimbursement of
29 Medicaid providers; amending s. 409.911, F.S.;
30 updating data requirements and share rates for
31 disproportionate share distributions; amending

1 s. 409.9116, F.S.; modifying the formula for
2 disproportionate share/financial assistance
3 distribution to rural hospitals; amending s.
4 409.91195, F.S.; requiring the Medicaid
5 Pharmaceutical and Therapeutics Committee to
6 recommend a preferred drug formulary; revising
7 the membership of the Medicaid Pharmaceutical
8 and Therapeutics Committee; authorizing the
9 Agency for Health Care Administration to
10 implement a prior authorization program for
11 outpatient prescription drugs under the
12 Medicaid program; providing duties of the
13 committee in advising the agency with respect
14 to prior authorization for drugs; providing
15 requirements for the program; requiring public
16 notice and comment; requiring the committee to
17 develop a grievance mechanism; requiring the
18 agency to publish the preferred drug formulary;
19 amending s. 409.912, F.S.; authorizing the
20 agency to establish requirements for prior
21 authorization for certain populations, drug
22 classes, or particular drugs; specifying
23 conditions under which the agency may enter
24 certain contracts with exclusive provider
25 organizations; revising components of the
26 agency's spending-control program; prescribing
27 additional services that the agency may provide
28 through competitive bidding; authorizing the
29 agency to establish, and make exceptions to, a
30 restricted-drug formulary; directing the agency
31 to establish a demonstration project in

1 Miami-Dade County to provide minority health
2 care; amending s. 409.9122, F.S.; providing for
3 disproportionate assignment of certain
4 Medicaid-eligible children to children's clinic
5 networks; providing for assignment of certain
6 Medicaid recipients to managed-care plans;
7 amending s. 409.915, F.S.; exempting counties
8 from contributing toward the increased cost of
9 hospital inpatient services due to elimination
10 of Medicaid ceilings on certain types of
11 hospitals and for special Medicaid
12 reimbursement to hospitals; revising the level
13 of county participation; providing for
14 distribution of funds under the
15 disproportionate share program for specified
16 hospitals for the 2001 federal fiscal year;
17 providing effective dates.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Subsections (9), (10), and (11) are added
22 to section 409.904, Florida Statutes, to read:
23 409.904 Optional payments for eligible persons.--The
24 agency may make payments for medical assistance and related
25 services on behalf of the following persons who are determined
26 to be eligible subject to the income, assets, and categorical
27 eligibility tests set forth in federal and state law. Payment
28 on behalf of these Medicaid eligible persons is subject to the
29 availability of moneys and any limitations established by the
30 General Appropriations Act or chapter 216.
31

1 (9) A Medicaid-eligible individual for the
2 individual's health insurance premiums, if the agency
3 determines that such payments are cost-effective.
4 (10) Eligible women with incomes below 200 percent of
5 the federal poverty level and under age 65, for cancer
6 treatment pursuant to the federal Breast and Cervical Cancer
7 Prevention and Treatment Act of 2000, screened through the
8 National Breast and Cervical Cancer Early Detection program.
9 (11) Subject to specific federal authorization, a
10 person who, but for earnings in excess of the limit
11 established under s. 1905(q)(2)(B) of the Social Security Act,
12 would be considered for receiving supplemental security
13 income, who is at least 16 but less than 65 years of age, and
14 whose assets, resources, and earned or unearned income, or
15 both, do not exceed 250 percent of the most current federal
16 poverty level. Such persons may be eligible for Medicaid
17 services as part of a Medicaid buy-in established under s.
18 409.914(2) specifically designed to accommodate those persons
19 made eligible for such a buy-in by Title II of Pub. L. No.
20 106-170. Such buy-in shall include income-related premiums and
21 cost sharing.
22 Section 2. Subject to a specific appropriation, the
23 Agency for Health Care Administration is directed to seek a
24 federal grant, demonstration project, or waiver, as may be
25 authorized by the United States Department of Health and Human
26 Services, for purposes of establishing a Medicaid buy-in
27 program or other programs to assist individuals with
28 disabilities in gaining employment. The services to be
29 provided are those required to enable such individuals to gain
30 or keep employment. The grant, demonstration project, or
31 waiver shall be submitted to the Secretary of Health and Human

1 Services at such time, in such manner, and containing such
2 information as the secretary shall require, as authorized
3 under Title II of Pub. L. No. 106-170, the "Ticket to Work and
4 Work Incentives Act of 1999."
5 Section 3. Subsection (5) of section 409.905, Florida
6 Statutes, is amended to read:
7 409.905 Mandatory Medicaid services.--The agency may
8 make payments for the following services, which are required
9 of the state by Title XIX of the Social Security Act,
10 furnished by Medicaid providers to recipients who are
11 determined to be eligible on the dates on which the services
12 were provided. Any service under this section shall be
13 provided only when medically necessary and in accordance with
14 state and federal law. Nothing in this section shall be
15 construed to prevent or limit the agency from adjusting fees,
16 reimbursement rates, lengths of stay, number of visits, number
17 of services, or any other adjustments necessary to comply with
18 the availability of moneys and any limitations or directions
19 provided for in the General Appropriations Act or chapter 216.
20 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay
21 for all covered services provided for the medical care and
22 treatment of a recipient who is admitted as an inpatient by a
23 licensed physician or dentist to a hospital licensed under
24 part I of chapter 395. However, the agency shall limit the
25 payment for inpatient hospital services for a Medicaid
26 recipient 21 years of age or older to 45 days or the number of
27 days necessary to comply with the General Appropriations Act.
28 (a) The agency is authorized to implement
29 reimbursement and utilization management reforms in order to
30 comply with any limitations or directions in the General
31 Appropriations Act, which may include, but are not limited to:

1 prior authorization for inpatient psychiatric days; prior
2 authorization for nonemergency hospital inpatient admissions
3 for individuals 21 years of age and older; authorization of
4 emergency and urgent-care admissions within 24 hours after
5 admission;enhanced utilization and concurrent review programs
6 for highly utilized services; reduction or elimination of
7 covered days of service; adjusting reimbursement ceilings for
8 variable costs; adjusting reimbursement ceilings for fixed and
9 property costs; and implementing target rates of increase. The
10 agency may limit prior authorization for hospital inpatient
11 services to selected diagnosis-related groups, based on an
12 analysis of the cost and potential for unnecessary
13 hospitalizations represented by certain diagnoses. Admissions
14 for normal delivery and newborns are exempt from requirements
15 for prior authorization. In implementing the provisions of
16 this section related to prior authorization, the agency shall
17 ensure that the process for authorization is accessible 24
18 hours per day, 7 days per week and authorization is
19 automatically granted when not denied within 4 hours after the
20 request. Authorization procedures must include steps for
21 review of denials. Upon implementing the prior authorization
22 program for hospital inpatient services, the agency shall
23 discontinue its hospital retrospective review program.
24 (b) A licensed hospital maintained primarily for the
25 care and treatment of patients having mental disorders or
26 mental diseases is not eligible to participate in the hospital
27 inpatient portion of the Medicaid program except as provided
28 in federal law. However, the department shall apply for a
29 waiver, within 9 months after June 5, 1991, designed to
30 provide hospitalization services for mental health reasons to
31 children and adults in the most cost-effective and lowest cost

1 setting possible. Such waiver shall include a request for the
2 opportunity to pay for care in hospitals known under federal
3 law as "institutions for mental disease" or "IMD's." The
4 waiver proposal shall propose no additional aggregate cost to
5 the state or Federal Government, and shall be conducted in
6 Hillsborough County, Highlands County, Hardee County, Manatee
7 County, and Polk County. The waiver proposal may incorporate
8 competitive bidding for hospital services, comprehensive
9 brokering, prepaid capitated arrangements, or other mechanisms
10 deemed by the department to show promise in reducing the cost
11 of acute care and increasing the effectiveness of preventive
12 care. When developing the waiver proposal, the department
13 shall take into account price, quality, accessibility,
14 linkages of the hospital to community services and family
15 support programs, plans of the hospital to ensure the earliest
16 discharge possible, and the comprehensiveness of the mental
17 health and other health care services offered by participating
18 providers.
19 (c) Agency for Health Care Administration shall adjust
20 a hospital's current inpatient per diem rate to reflect the
21 cost of serving the Medicaid population at that institution
22 if:
23 1. The hospital experiences an increase in Medicaid
24 caseload by more than 25 percent in any year, primarily
25 resulting from the closure of a hospital in the same service
26 area occurring after July 1, 1995; or
27 2. The hospital's Medicaid per diem rate is at least
28 25 percent below the Medicaid per patient cost for that year.
29
30 No later than November 1, <u>2001</u> ~~2000~~, the agency must provide
31 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 4. Subsection (8) of section 409.906, Florida Statutes, is amended, and subsection (25) is added to that section, 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

1 criteria in setting reimbursement rates, to preauthorize
2 certain high-cost or highly utilized services, to limit or
3 eliminate coverage for certain services, or to make any other
4 adjustments necessary to comply with any limitations or
5 directions provided for in the General Appropriations Act.
6 (b) The agency is authorized to implement
7 reimbursement and use management reforms in order to comply
8 with any limitations or directions in the General
9 Appropriations Act, which may include, but are not limited to:
10 prior authorization of treatment and service plans; prior
11 authorization of services; enhanced use review programs for
12 highly used services; and limits on services for those
13 determined to be abusing their benefit coverages.
14 (25) ASSISTIVE-CARE SERVICES.--The agency may pay for
15 assistive-care services provided to recipients with functional
16 or cognitive impairments residing in assisted living
17 facilities, adult family-care homes, or residential treatment
18 facilities. These services may include health support,
19 assistance with the activities of daily living and the
20 instrumental acts of daily living, assistance with medication
21 administration, and arrangements for health care.
22 Section 5. Paragraph (a) of subsection (1), paragraph
23 (b) of subsection (2), and subsections (4), (9), (11), (13),
24 (14), and (18) of section 409.908, Florida Statutes, are
25 amended, and subsection (22) is added to that section, to
26 read:
27 409.908 Reimbursement of Medicaid providers.--Subject
28 to specific appropriations, the agency shall reimburse
29 Medicaid providers, in accordance with state and federal law,
30 according to methodologies set forth in the rules of the
31 agency and in policy manuals and handbooks incorporated by

1 reference therein. These methodologies may include fee
2 schedules, reimbursement methods based on cost reporting,
3 negotiated fees, competitive bidding pursuant to s. 287.057,
4 and other mechanisms the agency considers efficient and
5 effective for purchasing services or goods on behalf of
6 recipients. Payment for Medicaid compensable services made on
7 behalf of Medicaid eligible persons is subject to the
8 availability of moneys and any limitations or directions
9 provided for in the General Appropriations Act or chapter 216.
10 Further, nothing in this section shall be construed to prevent
11 or limit the agency from adjusting fees, reimbursement rates,
12 lengths of stay, number of visits, or number of services, or
13 making any other adjustments necessary to comply with the
14 availability of moneys and any limitations or directions
15 provided for in the General Appropriations Act, provided the
16 adjustment is consistent with legislative intent.
17 (1) Reimbursement to hospitals licensed under part I
18 of chapter 395 must be made prospectively or on the basis of
19 negotiation.
20 (a) Reimbursement for inpatient care is limited as
21 provided for in s. 409.905(5), except for:
22 1. The raising of rate reimbursement caps, excluding
23 rural hospitals.
24 2. Recognition of the costs of graduate medical
25 education.
26 3. Other methodologies recognized in the General
27 Appropriations Act.
28
29 During the years funds are transferred from the Department of
30 Health ~~Board of Regents~~, any reimbursement supported by such
31 funds shall be subject to certification by the Department of

1 Health ~~Board of Regents~~ that the hospital has complied with s.
2 381.0403. The agency is authorized to receive funds from state
3 entities, including, but not limited to, the Department of
4 Health ~~Board of Regents~~, local governments, and other local
5 political subdivisions, for the purpose of making special
6 exception payments, including federal matching funds, through
7 the Medicaid inpatient reimbursement methodologies. Funds
8 received from state entities or local governments for this
9 purpose shall be separately accounted for and shall not be
10 commingled with other state or local funds in any manner. The
11 agency may certify all local governmental funds used as state
12 match under Title XIX of the Social Security Act, to the
13 extent that the identified local health care provider that is
14 otherwise entitled to and is contracted to receive such local
15 funds is the benefactor under the state's Medicaid program as
16 determined under the General Appropriations Act and pursuant
17 to an agreement between the Agency for Health Care
18 Administration and the local governmental entity. The local
19 governmental entity shall use a certification form prescribed
20 by the agency. At a minimum, the certification form shall
21 identify the amount being certified and describe the
22 relationship between the certifying local governmental entity
23 and the local health care provider. The agency shall prepare
24 an annual statement of impact which documents the specific
25 activities undertaken during the previous fiscal year pursuant
26 to this paragraph, to be submitted to the Legislature no later
27 than January 1, annually.~~Notwithstanding this section and s.~~
28 ~~409.915, counties are exempt from contributing toward the cost~~
29 ~~of the special exception reimbursement for hospitals serving a~~
30 ~~disproportionate share of low-income persons and providing~~
31 ~~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. The agency shall not provide for any increases for patient care or operating components of reimbursement rates to nursing homes associated with changes in ownership or licensed operators filed on or after October 1, 2001.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~~

1 ~~required to report to the agency information necessary to~~
2 ~~compile this report. Effective no earlier than the~~
3 ~~rate-setting period beginning April 1, 1999,~~The agency shall
4 establish a case-mix reimbursement methodology for the rate of
5 payment for long-term care services for nursing home
6 residents. The agency shall compute a per diem rate for
7 Medicaid residents, adjusted for case mix, which is based on a
8 resident classification system that accounts for the relative
9 resource utilization by different types of residents and which
10 is based on level-of-care data and other appropriate data. The
11 case-mix methodology developed by the agency shall take into
12 account the medical, behavioral, and cognitive deficits of
13 residents. In developing the reimbursement methodology, the
14 agency shall evaluate and modify other aspects of the
15 reimbursement plan as necessary to improve the overall
16 effectiveness of the plan with respect to the costs of patient
17 care, operating costs, and property costs. In the event
18 adequate data are not available, the agency is authorized to
19 adjust the patient's care component or the per diem rate to
20 more adequately cover the cost of services provided in the
21 patient's care component. The agency shall work with the
22 Department of Elderly Affairs, the Florida Health Care
23 Association, and the Florida Association of Homes for the
24 Aging in developing the methodology. It is the intent of the
25 Legislature that the reimbursement plan achieve the goal of
26 providing access to health care for nursing home residents who
27 require large amounts of care while encouraging diversion
28 services as an alternative to nursing home care for residents
29 who can be served within the community. The agency shall base
30 the establishment of any maximum rate of payment, whether
31 overall or component, on the available moneys as provided for

1 in the General Appropriations Act. The agency may base the
2 maximum rate of payment on the results of scientifically valid
3 analysis and conclusions derived from objective statistical
4 data pertinent to the particular maximum rate of payment.
5 (4) Subject to any limitations or directions provided
6 for in the General Appropriations Act, alternative health
7 plans, health maintenance organizations, and prepaid health
8 plans shall be reimbursed a fixed, prepaid amount negotiated,
9 or competitively bid pursuant to s. 287.057, by the agency and
10 prospectively paid to the provider monthly for each Medicaid
11 recipient enrolled. The amount may not exceed the average
12 amount the agency determines it would have paid, based on
13 claims experience, for recipients in the same or similar
14 category of eligibility. The agency shall calculate
15 capitation rates on a regional basis and, beginning September
16 1, 1995, shall include age-band differentials in such
17 calculations. Effective July 1, 2001, the cost of exempting
18 statutory teaching hospitals, specialty hospitals, and
19 community hospital education program hospitals from
20 reimbursement ceilings and the cost of special Medicaid
21 payments shall not be included in premiums paid to health
22 maintenance organizations or prepaid health care plans.
23 (9) A provider of home health care services or of
24 medical supplies and appliances shall be reimbursed on the
25 basis of competitive bidding or for the lesser of the amount
26 billed by the provider or the agency's established maximum
27 allowable amount, except that, in the case of the rental of
28 durable medical equipment, the total rental payments may not
29 exceed the purchase price of the equipment over its expected
30 useful life or the agency's established maximum allowable
31 amount, whichever amount is less.

1 (11) A provider of independent laboratory services
2 shall be reimbursed on the basis of competitive bidding or for
3 the least of the amount billed by the provider, the provider's
4 usual and customary charge, or the Medicaid maximum allowable
5 fee established by the agency.
6 (13) Medicare premiums for persons eligible for both
7 Medicare and Medicaid coverage shall be paid at the rates
8 established by Title XVIII of the Social Security Act. For
9 Medicare services rendered to Medicaid-eligible persons,
10 Medicaid shall pay Medicare deductibles and coinsurance as
11 follows:
12 (a) Medicaid shall make no payment toward deductibles
13 and coinsurance for any service that is not covered by
14 Medicaid.
15 (b) Medicaid's financial obligation for deductibles
16 and coinsurance payments shall be based on Medicare allowable
17 fees, not on a provider's billed charges.
18 (c) Medicaid will pay no portion of Medicare
19 deductibles and coinsurance when payment that Medicare has
20 made for the service equals or exceeds what Medicaid would
21 have paid if it had been the sole payor. The combined payment
22 of Medicare and Medicaid shall not exceed the amount Medicaid
23 would have paid had it been the sole payor. The Legislature
24 finds that there has been confusion regarding the
25 reimbursement for services rendered to dually eligible
26 Medicare beneficiaries. Accordingly, the Legislature clarifies
27 that it has always been the intent of the Legislature before
28 and after 1991 that, in reimbursing in accordance with fees
29 established by Title XVIII for premiums, deductibles, and
30 coinsurance for Medicare services rendered by physicians to
31 Medicaid eligible persons, physicians be reimbursed at the

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1 lesser of the amount billed by the physician or the Medicaid
2 maximum allowable fee established by the Agency for Health
3 Care Administration, as is permitted by federal law. It has
4 never been the intent of the Legislature with regard to such
5 services rendered by physicians that Medicaid be required to
6 provide any payment for deductibles, coinsurance, or
7 copayments for Medicare cost sharing, or any expenses incurred
8 relating thereto, in excess of the payment amount provided for
9 under the State Medicaid plan for such service. This payment
10 methodology is applicable even in those situations in which
11 the payment for Medicare cost sharing for a qualified Medicare
12 beneficiary with respect to an item or service is reduced or
13 eliminated. This expression of the Legislature is in
14 clarification of existing law and shall apply to payment for,
15 and with respect to provider agreements with respect to, items
16 or services furnished on or after the effective date of this
17 act. This paragraph applies to payment by Medicaid for items
18 and services furnished before the effective date of this act
19 if such payment is the subject of a lawsuit that is based on
20 the provisions of this section, and that is pending as of, or
21 is initiated after, the effective date of this act.
22 (d) Notwithstanding ~~The following provisions are~~
23 ~~exceptions to~~ paragraphs (a)-(c):
24 1. Medicaid payments for Nursing Home Medicare part A
25 coinsurance shall be the lesser of the Medicare coinsurance
26 amount or the Medicaid nursing home per diem rate.
27 ~~2. Medicaid shall pay all deductibles and coinsurance~~
28 ~~for Nursing Home Medicare part B services.~~
29 2.~~3.~~ Medicaid shall pay all deductibles and
30 coinsurance for Medicare-eligible recipients receiving
31 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 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

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1 when services are provided pursuant to an agreement negotiated
2 between the agency and the provider. The agency, as provided
3 for in s. 427.0135, shall purchase transportation services
4 through the community coordinated transportation system, if
5 available, unless the agency determines a more cost-effective
6 method for Medicaid clients. Nothing in this subsection shall
7 be construed to limit or preclude the agency from contracting
8 for services using a prepaid capitation rate or from
9 establishing maximum fee schedules, individualized
10 reimbursement policies by provider type, negotiated fees,
11 prior authorization, competitive bidding, increased use of
12 mass transit, or any other mechanism that the agency considers
13 efficient and effective for the purchase of services on behalf
14 of Medicaid clients, including implementing a transportation
15 eligibility process. The agency shall not be required to
16 contract with any community transportation coordinator or
17 transportation operator that has been determined by the
18 agency, the Department of Legal Affairs Medicaid Fraud Control
19 Unit, or any other state or federal agency to have engaged in
20 any abusive or fraudulent billing activities. The agency is
21 authorized to competitively procure transportation services or
22 make other changes necessary to secure approval of federal
23 waivers needed to permit federal financing of Medicaid
24 transportation services at the service matching rate rather
25 than the administrative matching rate.
26 (22) The agency may request and implement Medicaid
27 waivers from the federal Health Care Financing Administration
28 to advance and treat a portion of the Medicaid nursing home
29 per diem as capital for creating and operating a
30 risk-retention group for self-insurance purposes, consistent
31 with federal and state laws and rules.

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:

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(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. 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

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

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

1 DAERH = [(TAERH x ATARH)/STAERH]
2
3 Where:
4 DAERH = distribution amount for each rural hospital.
5 (f) Federal matching funds for the disproportionate
6 share program shall then be calculated for those hospitals
7 that qualify for disproportionate share in paragraph (e).
8 (g) State-funds-only payment amounts calculated under
9 paragraph (c) and corresponding federal matching funds are
10 then added to the results of paragraph (f) to determine the
11 total distribution amount for each rural hospital.
12 ~~In determining the payment amount for each rural~~
13 ~~hospital under this section, the agency shall first allocate~~
14 ~~all available state funds by the following formula:~~
15
16 ~~DAER = (TAERH x TARH)/STAERH~~
17
18 ~~Where:~~
19 ~~DAER = distribution amount for each rural hospital.~~
20 ~~STAERH = sum of total amount earned by each rural~~
21 ~~hospital.~~
22 ~~TAERH = total amount earned by each rural hospital.~~
23 ~~TARH = total amount appropriated or distributed under~~
24 ~~this section.~~
25
26 ~~Federal matching funds for the disproportionate share program~~
27 ~~shall then be calculated for those hospitals that qualify for~~
28 ~~disproportionate share payments under this section.~~
29 Section 8. Section 409.91195, Florida Statutes, is
30 amended to read:
31 (Substantial rewording of section. See

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1 s. 409.91195, F.S., for present text.)
2 409.91195 Medicaid Pharmaceutical and Therapeutics
3 Committee.--There is created a Medicaid Pharmaceutical and
4 Therapeutics Committee for the purpose of developing a
5 preferred drug formulary and prior authorization program for
6 prescriptions for Medicaid patients. The formulary shall
7 include medically appropriate and cost-effective prescription
8 drug therapies and shall meet all the federal requirements of
9 42 U.S.C. s. 1396r-8. Each therapeutic drug class or subclass
10 included in the preferred drug formulary must contain a
11 sufficient variety and number of agents reflective of current
12 utilization patterns and of appropriate therapeutic and
13 clinical response ranges targeted to the specialized needs of
14 an ethnically diverse, elderly, co-morbid, and medically
15 complex population. The Medicaid Pharmaceutical and
16 Therapeutics Committee shall review all drug classes included
17 in the preferred drug formulary every 6 months and make
18 recommendations for additions or modifications specific to the
19 population based on clinical literature and published studies
20 whenever appropriate. The Agency for Health Care
21 Administration shall engage an independent academic and
22 clinical team to review the administrative and clinical
23 decisionmaking procedures and conduct outcome-based
24 evaluations on affected patients at least annually and present
25 its findings and recommendations to the agency and the
26 Legislature.
27 (1) Notwithstanding any other law, the Agency for
28 Health Care Administration may implement a prior authorization
29 program for outpatient prescription drugs under the Medicaid
30 prescription drug program.
31

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1 (a) The Medicaid Pharmaceutical and Therapeutics
2 Committee shall be comprised of nine members as specified in
3 42 U.S.C. s. 11396 appointed by the Governor as follows: one
4 practicing physician licensed under chapter 458, from a list
5 of recommendations from the Florida Medical Association; one
6 participating physician licensed under chapter 459, from a
7 list of recommendations from the Florida Osteopathic Medical
8 Association; one practicing physician licensed under chapter
9 458, from a list of recommendations from the Florida Academy
10 of Family Physicians; one practicing physician licensed under
11 chapter 458, from a list of recommendations from the Florida
12 Pediatric Society; one participating physician licensed under
13 chapter 458, from a list of recommendations from the Florida
14 Psychiatric Society; one practicing dentist licensed under
15 chapter 466, from a list of recommendations from the Florida
16 Dental Association; one practicing pharmacist licensed under
17 chapter 465, from a list of recommendations from the Florida
18 Pharmacy Association; one practicing pharmacist under chapter
19 465, from a list of recommendations provided by the Florida
20 Society of Health System Pharmacists; and one health care
21 consumer or representative of a statewide voluntary health
22 association with a national affiliation from a list of
23 recommendations from the Pharmaceutical Research and
24 Manufacturers of America. The committee is established within
25 the Agency for Health Care Administration for the purposes of
26 developing a preferred drug formulary and implementing prior
27 authorization for outpatient prescription drugs under the
28 Medicaid program. Committee members shall serve staggered
29 3-year terms. Two physicians, one pharmacist, and one dentist
30 shall each be initially appointed for 2-year terms and three
31 physicians, one pharmacist, and one consumer representative

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1 shall each be initially appointed for 1-year terms. Members
2 may be reappointed for a period not to exceed three 3-year
3 terms. Vacancies on the committee shall be filled for the
4 balance of the unexpired term from nominee lists for the
5 appropriate category as provided in this paragraph.
6 (b) Committee members shall select a chairperson and a
7 vice chairperson each year from the committee membership.
8 (c) The committee shall meet at least quarterly and
9 may meet at other times at the discretion of the chairperson.
10 Notice of any meeting of the committee shall be published in
11 accordance with the Administrative Procedure Act. Committee
12 meetings shall in all respects comply with s. 286.011 and
13 shall be subject to the Administrative Procedure Act.
14 (2) The committee shall:
15 (a) Advise and make recommendations regarding rules to
16 be adopted by the Agency for Health Care Administration
17 regarding prior authorization for outpatient prescription
18 drugs.
19 (b) Oversee the implementation of a drug prior
20 authorization program for the Medicaid program.
21 (c) Establish the drug prior authorization review
22 process in compliance with subsection (3).
23 (d) Make formal recommendations to the Agency for
24 Health Care Administration regarding any outpatient
25 prescription drug covered by the Medicaid program which
26 requires prior authorization.
27 (e) Review semiannually whether drugs requiring prior
28 authorization should remain on prior authorization.
29 (3)(a) The drug prior authorization program shall
30 provide for telephone, fax, or other electronically
31

1 transmitted approval or denial within 24 hours after receipt
2 of a request for prior authorization.
3 (b) In an emergency situation, including a situation
4 in which a response to a prior authorization request is
5 unavailable, a 72-hour supply of the prescribed drug shall be
6 dispensed and paid for by the medical assistance program or,
7 at the discretion of the committee, a supply greater than a
8 72-hour supply may be dispensed in order to assure a minimum
9 effective duration of therapy for an acute intervention.
10 (c) Upon verbal consultation with a prescribing
11 provider, a 12-month authorization shall be granted if the
12 drug is prescribed for a medically accepted use that is
13 supported by the compendia, approved product labeling, or
14 peer-reviewed literature, unless there is a chemically
15 equivalent generic drug that is available without prior
16 authorization.
17 (4)(a) The committee shall analyze the retrospective
18 drug utilization review data using the utilization criteria to
19 identify a drug for which the use is likely not to be
20 medically appropriate or medically necessary, or which is
21 likely to result in adverse medical outcomes.
22 (b) The committee shall consider the potential impact
23 on patient care and the potential fiscal impact that may
24 result from placement of the drug on prior authorization.
25 (c) Any consideration of the cost of the drug by the
26 committee must reflect the total cost of treating the
27 conditions for which the drug is prescribed, including
28 nonpharmaceutical costs and costs incurred by other sectors of
29 the state health care program which may be affected by the
30 drug's availability for use in treating program beneficiaries.
31

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1 (d) The committee shall provide public notice of any
2 meeting for developing recommendations concerning whether such
3 a drug should be placed on prior authorization. Any interested
4 party may request an opportunity to make an oral presentation
5 to the committee related to the prior authorization of the
6 drug. The committee shall also consider any information
7 provided by any interested party, including, but not limited
8 to, physicians, pharmacists, beneficiaries, and manufacturers
9 or distributors of the drug.
10 (e) The committee shall make a formal written
11 recommendation to the Agency for Health Care Administration
12 that such a drug be placed on prior authorization, which must
13 be supported by an analysis of prospective and retrospective
14 drug utilization review data that demonstrates:
15 1. The expected impact of such a decision on the
16 clinical care likely to be received by beneficiaries for whom
17 the drug is medically necessary;
18 2. The expected impact on physicians whose patients
19 require the drug;
20 3. The expected fiscal impact on the medical
21 assistance program; and
22 4. Established national treatment guidelines or
23 specific protocol criteria that may be applied for each drug
24 recommended.
25 (f) The Agency for Health Care Administration shall
26 accept or reject the recommendations of the committee and, in
27 a written decision, shall determine whether such drug should
28 be placed on prior authorization. The agency may consider any
29 additional and clarifying information provided by any
30 interested party in rendering its decision.
31

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1 (g) The agency's decision shall be published for
2 comment for at least 30 days. The effective date of the
3 decision may not be prior to the close of the comment period,
4 and the effective notice of the decision's finality shall be
5 available to prescribers.
6 (5) Notwithstanding any other provision of this
7 section, a drug may not be recommended for prior authorization
8 by the committee or placed on prior authorization by the
9 agency if the drug has been approved or has had any of its
10 particular uses approved by the United States Food and Drug
11 Administration under a priority review classification.
12 (6) The committee shall develop a grievance mechanism
13 by which interested parties may appeal the agency's decision
14 to place a drug on prior authorization. After participating in
15 the grievance mechanism developed by the committee, any
16 interested party aggrieved by the placement of a drug on prior
17 authorization is entitled to an administrative hearing before
18 the agency pursuant to chapter 120.
19 (a) The committee shall review the prior authorization
20 status of a drug every 6 months.
21 (b) The committee shall provide public notice prior to
22 any meeting determining whether changes should be made to the
23 drug prior authorization review process.
24 (c) The Agency for Health Care Administration shall
25 publish and disseminate the preferred drug formulary to all
26 Medicaid prescribers of drugs in this state.
27 Section 9. Section 409.912, Florida Statutes, is
28 amended to read:
29 409.912 Cost-effective purchasing of health care.--The
30 agency shall purchase goods and services for Medicaid
31 recipients in the most cost-effective manner consistent with

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1 the delivery of quality medical care. The agency shall
2 maximize the use of prepaid per capita and prepaid aggregate
3 fixed-sum basis services when appropriate and other
4 alternative service delivery and reimbursement methodologies,
5 including competitive bidding pursuant to s. 287.057, designed
6 to facilitate the cost-effective purchase of a case-managed
7 continuum of care. The agency shall also require providers to
8 minimize the exposure of recipients to the need for acute
9 inpatient, custodial, and other institutional care and the
10 inappropriate or unnecessary use of high-cost services. The
11 agency may establish prior authorization requirements for
12 certain populations of Medicaid beneficiaries, certain drug
13 classes, or particular drugs to prevent fraud, abuse, overuse,
14 and possible dangerous drug interactions. The Pharmaceutical
15 and Therapeutics Committee shall make recommendations to the
16 agency on drugs for which prior authorization is required. The
17 agency shall inform the Pharmaceutical and Therapeutics
18 Committee of its decisions regarding drugs subject to prior
19 authorization.
20 (1) The agency may enter into agreements with
21 appropriate agents of other state agencies or of any agency of
22 the Federal Government and accept such duties in respect to
23 social welfare or public aid as may be necessary to implement
24 the provisions of Title XIX of the Social Security Act and ss.
25 409.901-409.920.
26 (2) The agency may contract with health maintenance
27 organizations certified pursuant to part I of chapter 641 for
28 the provision of services to recipients.
29 (3) The agency may contract with:
30 (a) An entity that provides no prepaid health care
31 services other than Medicaid services under contract with the

1 agency and which is owned and operated by a county, county
2 health department, or county-owned and operated hospital to
3 provide health care services on a prepaid or fixed-sum basis
4 to recipients, which entity may provide such prepaid services
5 either directly or through arrangements with other providers.
6 Such prepaid health care services entities must be licensed
7 under parts I and III by January 1, 1998, and until then are
8 exempt from the provisions of part I of chapter 641. An entity
9 recognized under this paragraph which demonstrates to the
10 satisfaction of the Department of Insurance that it is backed
11 by the full faith and credit of the county in which it is
12 located may be exempted from s. 641.225.
13 (b) An entity that is providing comprehensive
14 behavioral health care services to certain Medicaid recipients
15 through a capitated, prepaid arrangement pursuant to the
16 federal waiver provided for by s. 409.905(5). Such an entity
17 must be licensed under chapter 624, chapter 636, or chapter
18 641 and must possess the clinical systems and operational
19 competence to manage risk and provide comprehensive behavioral
20 health care to Medicaid recipients. As used in this paragraph,
21 the term "comprehensive behavioral health care services" means
22 covered mental health and substance abuse treatment services
23 that are available to Medicaid recipients. The secretary of
24 the Department of Children and Family Services shall approve
25 provisions of procurements related to children in the
26 department's care or custody prior to enrolling such children
27 in a prepaid behavioral health plan. Any contract awarded
28 under this paragraph must be competitively procured. In
29 developing the behavioral health care prepaid plan procurement
30 document, the agency shall ensure that the procurement
31 document requires the contractor to develop and implement a

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1 plan to ensure compliance with s. 394.4574 related to services
2 provided to residents of licensed assisted living facilities
3 that hold a limited mental health license. The agency must
4 ensure that Medicaid recipients have available the choice of
5 at least two managed care plans for their behavioral health
6 care services. The agency may reimburse for
7 substance-abuse-treatment services on a fee-for-service basis
8 until the agency finds that adequate funds are available for
9 capitated, prepaid arrangements.
10 1. By January 1, 2001, the agency shall modify the
11 contracts with the entities providing comprehensive inpatient
12 and outpatient mental health care services to Medicaid
13 recipients in Hillsborough, Highlands, Hardee, Manatee, and
14 Polk Counties, to include substance-abuse-treatment services.
15 2. By December 31, 2001, the agency shall contract
16 with entities providing comprehensive behavioral health care
17 services to Medicaid recipients through capitated, prepaid
18 arrangements in Charlotte, Collier, DeSoto, Escambia, Glades,
19 Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota,
20 and Walton Counties. The agency may contract with entities
21 providing comprehensive behavioral health care services to
22 Medicaid recipients through capitated, prepaid arrangements in
23 Alachua County. The agency may determine if Sarasota County
24 shall be included as a separate catchment area or included in
25 any other agency geographic area.
26 3. Children residing in a Department of Juvenile
27 Justice residential program approved as a Medicaid behavioral
28 health overlay services provider shall not be included in a
29 behavioral health care prepaid health plan pursuant to this
30 paragraph.
31

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1 4. In converting to a prepaid system of delivery, the
2 agency shall in its procurement document require an entity
3 providing comprehensive behavioral health care services to
4 prevent the displacement of indigent care patients by
5 enrollees in the Medicaid prepaid health plan providing
6 behavioral health care services from facilities receiving
7 state funding to provide indigent behavioral health care, to
8 facilities licensed under chapter 395 which do not receive
9 state funding for indigent behavioral health care, or
10 reimburse the unsubsidized facility for the cost of behavioral
11 health care provided to the displaced indigent care patient.
12 5. Traditional community mental health providers under
13 contract with the Department of Children and Family Services
14 pursuant to part IV of chapter 394 and inpatient mental health
15 providers licensed pursuant to chapter 395 must be offered an
16 opportunity to accept or decline a contract to participate in
17 any provider network for prepaid behavioral health services.
18 (c) A federally qualified health center or an entity
19 owned by one or more federally qualified health centers or an
20 entity owned by other migrant and community health centers
21 receiving non-Medicaid financial support from the Federal
22 Government to provide health care services on a prepaid or
23 fixed-sum basis to recipients. Such prepaid health care
24 services entity must be licensed under parts I and III of
25 chapter 641, but shall be prohibited from serving Medicaid
26 recipients on a prepaid basis, until such licensure has been
27 obtained. However, such an entity is exempt from s. 641.225
28 if the entity meets the requirements specified in subsections
29 (14) and (15).
30 (d) No more than four provider service networks for
31 demonstration projects to test Medicaid direct contracting.

The demonstration projects may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. A demonstration project awarded pursuant to this paragraph shall be for 4 ~~2~~ years from the date of implementation.

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

(f) An entity in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases in order to test the cost-effectiveness of enhanced home-based medical care. The

1 entity providing the services shall be reimbursed on a
2 fee-for-service basis at a rate not less than comparable
3 Medicare reimbursement rates. The agency may apply for waivers
4 of federal regulations necessary to implement such program.
5 This paragraph shall be repealed on July 1, 2002.
6 (g) Children's provider networks that provide care
7 coordination and care management for Medicaid-eligible
8 pediatric patients, primary care, authorization of specialty
9 care, and other urgent and emergency care through organized
10 providers designed to service Medicaid eligibles under age 18.
11 The networks shall provide after-hour operations, including
12 evening and weekend hours, to promote, when appropriate, the
13 use of the children's networks rather than hospital emergency
14 departments.
15 (4) The agency may contract with any public or private
16 entity otherwise authorized by this section on a prepaid or
17 fixed-sum basis for the provision of health care services to
18 recipients. An entity may provide prepaid services to
19 recipients, either directly or through arrangements with other
20 entities, if each entity involved in providing services:
21 (a) Is organized primarily for the purpose of
22 providing health care or other services of the type regularly
23 offered to Medicaid recipients;
24 (b) Ensures that services meet the standards set by
25 the agency for quality, appropriateness, and timeliness;
26 (c) Makes provisions satisfactory to the agency for
27 insolvency protection and ensures that neither enrolled
28 Medicaid recipients nor the agency will be liable for the
29 debts of the entity;
30 (d) Submits to the agency, if a private entity, a
31 financial plan that the agency finds to be fiscally sound and

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1 that provides for working capital in the form of cash or
2 equivalent liquid assets excluding revenues from Medicaid
3 premium payments equal to at least the first 3 months of
4 operating expenses or $200,000, whichever is greater;
5 (e) Furnishes evidence satisfactory to the agency of
6 adequate liability insurance coverage or an adequate plan of
7 self-insurance to respond to claims for injuries arising out
8 of the furnishing of health care;
9 (f) Provides, through contract or otherwise, for
10 periodic review of its medical facilities and services, as
11 required by the agency; and
12 (g) Provides organizational, operational, financial,
13 and other information required by the agency.
14 (5) The agency may contract on a prepaid or fixed-sum
15 basis with any health insurer that:
16 (a) Pays for health care services provided to enrolled
17 Medicaid recipients in exchange for a premium payment paid by
18 the agency;
19 (b) Assumes the underwriting risk; and
20 (c) Is organized and licensed under applicable
21 provisions of the Florida Insurance Code and is currently in
22 good standing with the Department of Insurance.
23 (6) The agency may contract on a prepaid or fixed-sum
24 basis with an exclusive provider organization to provide
25 health care services to Medicaid recipients provided that ~~the~~
26 ~~contract does not cost more than a managed care plan contract~~
27 ~~in the same agency region and that~~ the exclusive provider
28 organization meets applicable managed care plan requirements
29 in this section, ss. 409.9122, 409.9123, 409.9128, and
30 627.6472, and other applicable provisions of law.
31

1 (7) The Agency for Health Care Administration may
2 provide cost-effective purchasing of chiropractic services on
3 a fee-for-service basis to Medicaid recipients through
4 arrangements with a statewide chiropractic preferred provider
5 organization incorporated in this state as a not-for-profit
6 corporation. The agency shall ensure that the benefit limits
7 and prior authorization requirements in the current Medicaid
8 program shall apply to the services provided by the
9 chiropractic preferred provider organization.
10 (8) The agency shall not contract on a prepaid or
11 fixed-sum basis for Medicaid services with an entity which
12 knows or reasonably should know that any officer, director,
13 agent, managing employee, or owner of stock or beneficial
14 interest in excess of 5 percent common or preferred stock, or
15 the entity itself, has been found guilty of, regardless of
16 adjudication, or entered a plea of nolo contendere, or guilty,
17 to:
18 (a) Fraud;
19 (b) Violation of federal or state antitrust statutes,
20 including those proscribing price fixing between competitors
21 and the allocation of customers among competitors;
22 (c) Commission of a felony involving embezzlement,
23 theft, forgery, income tax evasion, bribery, falsification or
24 destruction of records, making false statements, receiving
25 stolen property, making false claims, or obstruction of
26 justice; or
27 (d) Any crime in any jurisdiction which directly
28 relates to the provision of health services on a prepaid or
29 fixed-sum basis.
30 (9) The agency, after notifying the Legislature, may
31 apply for waivers of applicable federal laws and regulations

1 as necessary to implement more appropriate systems of health
2 care for Medicaid recipients and reduce the cost of the
3 Medicaid program to the state and federal governments and
4 shall implement such programs, after legislative approval,
5 within a reasonable period of time after federal approval.
6 These programs must be designed primarily to reduce the need
7 for inpatient care, custodial care and other long-term or
8 institutional care, and other high-cost services.
9 (a) Prior to seeking legislative approval of such a
10 waiver as authorized by this subsection, the agency shall
11 provide notice and an opportunity for public comment. Notice
12 shall be provided to all persons who have made requests of the
13 agency for advance notice and shall be published in the
14 Florida Administrative Weekly not less than 28 days prior to
15 the intended action.
16 (b) Notwithstanding s. 216.292, funds that are
17 appropriated to the Department of Elderly Affairs for the
18 Assisted Living for the Elderly Medicaid waiver and are not
19 expended shall be transferred to the agency to fund
20 Medicaid-reimbursed nursing home care.
21 (10) The agency shall establish a postpayment
22 utilization control program designed to identify recipients
23 who may inappropriately overuse or underuse Medicaid services
24 and shall provide methods to correct such misuse.
25 (11) The agency shall develop and provide coordinated
26 systems of care for Medicaid recipients and may contract with
27 public or private entities to develop and administer such
28 systems of care among public and private health care providers
29 in a given geographic area.
30
31

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1 (12) The agency shall operate or contract for the
2 operation of utilization management and incentive systems
3 designed to encourage cost-effective use services.
4 (13)(a) The agency shall identify health care
5 utilization and price patterns within the Medicaid program
6 which are not cost-effective or medically appropriate and
7 assess the effectiveness of new or alternate methods of
8 providing and monitoring service, and may implement such
9 methods as it considers appropriate. Such methods may include
10 disease management initiatives, an integrated and systematic
11 approach for managing the health care needs of recipients who
12 are at risk of or diagnosed with a specific disease by using
13 best practices, prevention strategies, clinical-practice
14 improvement, clinical interventions and protocols, outcomes
15 research, information technology, and other tools and
16 resources to reduce overall costs and improve measurable
17 outcomes.
18 (b) The responsibility of the agency under this
19 subsection shall include the development of capabilities to
20 identify actual and optimal practice patterns; patient and
21 provider educational initiatives; methods for determining
22 patient compliance with prescribed treatments; fraud, waste,
23 and abuse prevention and detection programs; and beneficiary
24 case management programs.
25 1. The practice pattern identification program shall
26 evaluate practitioner prescribing patterns based on national
27 and regional practice guidelines, comparing practitioners to
28 their peer groups. The agency and its Drug Utilization Review
29 Board shall consult with a panel of practicing health care
30 professionals consisting of the following: the Speaker of the
31 House of Representatives and the President of the Senate shall

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1 each appoint three physicians licensed under chapter 458 or
2 chapter 459; and the Governor shall appoint two pharmacists
3 licensed under chapter 465 and one dentist licensed under
4 chapter 466 who is an oral surgeon. Terms of the panel members
5 shall expire at the discretion of the appointing official. The
6 panel shall begin its work by August 1, 1999, regardless of
7 the number of appointments made by that date. The advisory
8 panel shall be responsible for evaluating treatment guidelines
9 and recommending ways to incorporate their use in the practice
10 pattern identification program. Practitioners who are
11 prescribing inappropriately or inefficiently, as determined by
12 the agency, may have their prescribing of certain drugs
13 subject to prior authorization.
14 2. The agency shall also develop educational
15 interventions designed to promote the proper use of
16 medications by providers and beneficiaries.
17 3. The agency shall implement a pharmacy fraud, waste,
18 and abuse initiative that may include a surety bond or letter
19 of credit requirement for participating pharmacies, enhanced
20 provider auditing practices, the use of additional fraud and
21 abuse software, recipient management programs for
22 beneficiaries inappropriately using their benefits, and other
23 steps that will eliminate provider and recipient fraud, waste,
24 and abuse. The initiative shall address enforcement efforts to
25 reduce the number and use of counterfeit prescriptions.
26 4. The agency may apply for any federal waivers needed
27 to implement this paragraph.
28 (14) An entity contracting on a prepaid or fixed-sum
29 basis shall, in addition to meeting any applicable statutory
30 surplus requirements, also maintain at all times in the form
31 of cash, investments that mature in less than 180 days

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1 allowable as admitted assets by the Department of Insurance,
2 and restricted funds or deposits controlled by the agency or
3 the Department of Insurance, a surplus amount equal to
4 one-and-one-half times the entity's monthly Medicaid prepaid
5 revenues. As used in this subsection, the term "surplus" means
6 the entity's total assets minus total liabilities. If an
7 entity's surplus falls below an amount equal to
8 one-and-one-half times the entity's monthly Medicaid prepaid
9 revenues, the agency shall prohibit the entity from engaging
10 in marketing and preenrollment activities, shall cease to
11 process new enrollments, and shall not renew the entity's
12 contract until the required balance is achieved. The
13 requirements of this subsection do not apply:
14 (a) Where a public entity agrees to fund any deficit
15 incurred by the contracting entity; or
16 (b) Where the entity's performance and obligations are
17 guaranteed in writing by a guaranteeing organization which:
18 1. Has been in operation for at least 5 years and has
19 assets in excess of $50 million; or
20 2. Submits a written guarantee acceptable to the
21 agency which is irrevocable during the term of the contracting
22 entity's contract with the agency and, upon termination of the
23 contract, until the agency receives proof of satisfaction of
24 all outstanding obligations incurred under the contract.
25 (15)(a) The agency may require an entity contracting
26 on a prepaid or fixed-sum basis to establish a restricted
27 insolvency protection account with a federally guaranteed
28 financial institution licensed to do business in this state.
29 The entity shall deposit into that account 5 percent of the
30 capitation payments made by the agency each month until a
31 maximum total of 2 percent of the total current contract

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1 amount is reached. The restricted insolvency protection
2 account may be drawn upon with the authorized signatures of
3 two persons designated by the entity and two representatives
4 of the agency. If the agency finds that the entity is
5 insolvent, the agency may draw upon the account solely with
6 the two authorized signatures of representatives of the
7 agency, and the funds may be disbursed to meet financial
8 obligations incurred by the entity under the prepaid contract.
9 If the contract is terminated, expired, or not continued, the
10 account balance must be released by the agency to the entity
11 upon receipt of proof of satisfaction of all outstanding
12 obligations incurred under this contract.
13 (b) The agency may waive the insolvency protection
14 account requirement in writing when evidence is on file with
15 the agency of adequate insolvency insurance and reinsurance
16 that will protect enrollees if the entity becomes unable to
17 meet its obligations.
18 (16) An entity that contracts with the agency on a
19 prepaid or fixed-sum basis for the provision of Medicaid
20 services shall reimburse any hospital or physician that is
21 outside the entity's authorized geographic service area as
22 specified in its contract with the agency, and that provides
23 services authorized by the entity to its members, at a rate
24 negotiated with the hospital or physician for the provision of
25 services or according to the lesser of the following:
26 (a) The usual and customary charges made to the
27 general public by the hospital or physician; or
28 (b) The Florida Medicaid reimbursement rate
29 established for the hospital or physician.
30 (17) When a merger or acquisition of a Medicaid
31 prepaid contractor has been approved by the Department of

1 Insurance pursuant to s. 628.4615, the agency shall approve
2 the assignment or transfer of the appropriate Medicaid prepaid
3 contract upon request of the surviving entity of the merger or
4 acquisition if the contractor and the other entity have been
5 in good standing with the agency for the most recent 12-month
6 period, unless the agency determines that the assignment or
7 transfer would be detrimental to the Medicaid recipients or
8 the Medicaid program. To be in good standing, an entity must
9 not have failed accreditation or committed any material
10 violation of the requirements of s. 641.52 and must meet the
11 Medicaid contract requirements. For purposes of this section,
12 a merger or acquisition means a change in controlling interest
13 of an entity, including an asset or stock purchase.
14 (18) Any entity contracting with the agency pursuant
15 to this section to provide health care services to Medicaid
16 recipients is prohibited from engaging in any of the following
17 practices or activities:
18 (a) Practices that are discriminatory, including, but
19 not limited to, attempts to discourage participation on the
20 basis of actual or perceived health status.
21 (b) Activities that could mislead or confuse
22 recipients, or misrepresent the organization, its marketing
23 representatives, or the agency. Violations of this paragraph
24 include, but are not limited to:
25 1. False or misleading claims that marketing
26 representatives are employees or representatives of the state
27 or county, or of anyone other than the entity or the
28 organization by whom they are reimbursed.
29 2. False or misleading claims that the entity is
30 recommended or endorsed by any state or county agency, or by
31

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1 any other organization which has not certified its endorsement
2 in writing to the entity.
3 3. False or misleading claims that the state or county
4 recommends that a Medicaid recipient enroll with an entity.
5 4. Claims that a Medicaid recipient will lose benefits
6 under the Medicaid program, or any other health or welfare
7 benefits to which the recipient is legally entitled, if the
8 recipient does not enroll with the entity.
9 (c) Granting or offering of any monetary or other
10 valuable consideration for enrollment, except as authorized by
11 subsection (21).
12 (d) Door-to-door solicitation of recipients who have
13 not contacted the entity or who have not invited the entity to
14 make a presentation.
15 (e) Solicitation of Medicaid recipients by marketing
16 representatives stationed in state offices unless approved and
17 supervised by the agency or its agent and approved by the
18 affected state agency when solicitation occurs in an office of
19 the state agency. The agency shall ensure that marketing
20 representatives stationed in state offices shall market their
21 managed care plans to Medicaid recipients only in designated
22 areas and in such a way as to not interfere with the
23 recipients' activities in the state office.
24 (f) Enrollment of Medicaid recipients.
25 (19) The agency may impose a fine for a violation of
26 this section or the contract with the agency by a person or
27 entity that is under contract with the agency. With respect
28 to any nonwillful violation, such fine shall not exceed $2,500
29 per violation. In no event shall such fine exceed an
30 aggregate amount of $10,000 for all nonwillful violations
31 arising out of the same action. With respect to any knowing

1 and willful violation of this section or the contract with the
2 agency, the agency may impose a fine upon the entity in an
3 amount not to exceed $20,000 for each such violation. In no
4 event shall such fine exceed an aggregate amount of $100,000
5 for all knowing and willful violations arising out of the same
6 action.
7 (20) A health maintenance organization or a person or
8 entity exempt from chapter 641 that is under contract with the
9 agency for the provision of health care services to Medicaid
10 recipients may not use or distribute marketing materials used
11 to solicit Medicaid recipients, unless such materials have
12 been approved by the agency. The provisions of this subsection
13 do not apply to general advertising and marketing materials
14 used by a health maintenance organization to solicit both
15 non-Medicaid subscribers and Medicaid recipients.
16 (21) Upon approval by the agency, health maintenance
17 organizations and persons or entities exempt from chapter 641
18 that are under contract with the agency for the provision of
19 health care services to Medicaid recipients may be permitted
20 within the capitation rate to provide additional health
21 benefits that the agency has found are of high quality, are
22 practicably available, provide reasonable value to the
23 recipient, and are provided at no additional cost to the
24 state.
25 (22) The agency shall utilize the statewide health
26 maintenance organization complaint hotline for the purpose of
27 investigating and resolving Medicaid and prepaid health plan
28 complaints, maintaining a record of complaints and confirmed
29 problems, and receiving disenrollment requests made by
30 recipients.
31

1 (23) The agency shall require the publication of the
2 health maintenance organization's and the prepaid health
3 plan's consumer services telephone numbers and the "800"
4 telephone number of the statewide health maintenance
5 organization complaint hotline on each Medicaid identification
6 card issued by a health maintenance organization or prepaid
7 health plan contracting with the agency to serve Medicaid
8 recipients and on each subscriber handbook issued to a
9 Medicaid recipient.
10 (24) The agency shall establish a health care quality
11 improvement system for those entities contracting with the
12 agency pursuant to this section, incorporating all the
13 standards and guidelines developed by the Medicaid Bureau of
14 the Health Care Financing Administration as a part of the
15 quality assurance reform initiative. The system shall
16 include, but need not be limited to, the following:
17 (a) Guidelines for internal quality assurance
18 programs, including standards for:
19 1. Written quality assurance program descriptions.
20 2. Responsibilities of the governing body for
21 monitoring, evaluating, and making improvements to care.
22 3. An active quality assurance committee.
23 4. Quality assurance program supervision.
24 5. Requiring the program to have adequate resources to
25 effectively carry out its specified activities.
26 6. Provider participation in the quality assurance
27 program.
28 7. Delegation of quality assurance program activities.
29 8. Credentialing and recredentialing.
30 9. Enrollee rights and responsibilities.
31

1 10. Availability and accessibility to services and
2 care.
3 11. Ambulatory care facilities.
4 12. Accessibility and availability of medical records,
5 as well as proper recordkeeping and process for record review.
6 13. Utilization review.
7 14. A continuity of care system.
8 15. Quality assurance program documentation.
9 16. Coordination of quality assurance activity with
10 other management activity.
11 17. Delivering care to pregnant women and infants; to
12 elderly and disabled recipients, especially those who are at
13 risk of institutional placement; to persons with developmental
14 disabilities; and to adults who have chronic, high-cost
15 medical conditions.
16 (b) Guidelines which require the entities to conduct
17 quality-of-care studies which:
18 1. Target specific conditions and specific health
19 service delivery issues for focused monitoring and evaluation.
20 2. Use clinical care standards or practice guidelines
21 to objectively evaluate the care the entity delivers or fails
22 to deliver for the targeted clinical conditions and health
23 services delivery issues.
24 3. Use quality indicators derived from the clinical
25 care standards or practice guidelines to screen and monitor
26 care and services delivered.
27 (c) Guidelines for external quality review of each
28 contractor which require: focused studies of patterns of care;
29 individual care review in specific situations; and followup
30 activities on previous pattern-of-care study findings and
31 individual-care-review findings. In designing the external

quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

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

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

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

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

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

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

(25) In order to ensure that children receive health care services for which an entity has already been compensated, an entity contracting with the agency pursuant to this section shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months. The agency shall develop a method by which the EPSDT screening rate shall be calculated. For any entity which does not achieve the annual 60 percent rate, the entity must submit a corrective action plan for the agency's approval. If the entity does not meet the standard

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1 established in the corrective action plan during the specified
2 timeframe, the agency is authorized to impose appropriate
3 contract sanctions. At least annually, the agency shall
4 publicly release the EPSDT Services screening rates of each
5 entity it has contracted with on a prepaid basis to serve
6 Medicaid recipients.
7 (26) The agency shall perform choice counseling,
8 enrollments, and disenrollments for Medicaid recipients who
9 are eligible for MediPass or managed care plans.
10 Notwithstanding the prohibition contained in paragraph
11 (18)(f), managed care plans may perform preenrollments of
12 Medicaid recipients under the supervision of the agency or its
13 agents. For the purposes of this section, "preenrollment"
14 means the provision of marketing and educational materials to
15 a Medicaid recipient and assistance in completing the
16 application forms, but shall not include actual enrollment
17 into a managed care plan. An application for enrollment shall
18 not be deemed complete until the agency or its agent verifies
19 that the recipient made an informed, voluntary choice. The
20 agency, in cooperation with the Department of Children and
21 Family Services, may test new marketing initiatives to inform
22 Medicaid recipients about their managed care options at
23 selected sites. The agency shall report to the Legislature on
24 the effectiveness of such initiatives. The agency may
25 contract with a third party to perform managed care plan and
26 MediPass choice-counseling, enrollment, and disenrollment
27 services for Medicaid recipients and is authorized to adopt
28 rules to implement such services. The agency may adjust the
29 capitation rate only to cover the costs of a third-party
30 choice-counseling, enrollment, and disenrollment contract, and
31

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1 for agency supervision and management of the managed care plan
2 choice-counseling, enrollment, and disenrollment contract.
3 (27) Any lists of providers made available to Medicaid
4 recipients, MediPass enrollees, or managed care plan enrollees
5 shall be arranged alphabetically showing the provider's name
6 and specialty and, separately, by specialty in alphabetical
7 order.
8 (28) The agency shall establish an enhanced managed
9 care quality assurance oversight function, to include at least
10 the following components:
11 (a) At least quarterly analysis and followup,
12 including sanctions as appropriate, of managed care
13 participant utilization of services.
14 (b) At least quarterly analysis and followup,
15 including sanctions as appropriate, of quality findings of the
16 Medicaid peer review organization and other external quality
17 assurance programs.
18 (c) At least quarterly analysis and followup,
19 including sanctions as appropriate, of the fiscal viability of
20 managed care plans.
21 (d) At least quarterly analysis and followup,
22 including sanctions as appropriate, of managed care
23 participant satisfaction and disenrollment surveys.
24 (e) The agency shall conduct regular and ongoing
25 Medicaid recipient satisfaction surveys.
26
27 The analyses and followup activities conducted by the agency
28 under its enhanced managed care quality assurance oversight
29 function shall not duplicate the activities of accreditation
30 reviewers for entities regulated under part III of chapter
31

1 641, but may include a review of the finding of such
2 reviewers.
3 (29) Each managed care plan that is under contract
4 with the agency to provide health care services to Medicaid
5 recipients shall annually conduct a background check with the
6 Florida Department of Law Enforcement of all persons with
7 ownership interest of 5 percent or more or executive
8 management responsibility for the managed care plan and shall
9 submit to the agency information concerning any such person
10 who has been found guilty of, regardless of adjudication, or
11 has entered a plea of nolo contendere or guilty to, any of the
12 offenses listed in s. 435.03.
13 (30) The agency shall, by rule, develop a process
14 whereby a Medicaid managed care plan enrollee who wishes to
15 enter hospice care may be disenrolled from the managed care
16 plan within 24 hours after contacting the agency regarding
17 such request. The agency rule shall include a methodology for
18 the agency to recoup managed care plan payments on a pro rata
19 basis if payment has been made for the enrollment month when
20 disenrollment occurs.
21 (31) The agency and entities which contract with the
22 agency to provide health care services to Medicaid recipients
23 under this section or s. 409.9122 must comply with the
24 provisions of s. 641.513 in providing emergency services and
25 care to Medicaid recipients and MediPass recipients.
26 (32) All entities providing health care services to
27 Medicaid recipients shall make available, and encourage all
28 pregnant women and mothers with infants to receive, and
29 provide documentation in the medical records to reflect, the
30 following:
31 (a) Healthy Start prenatal or infant screening.

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

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

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

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

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

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

(33) Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.

(34) The agency may seek and implement federal waivers necessary to provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, and durable medical equipment and supplies through competitive bidding ~~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.

(35) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory, diagnostic imaging, and specified home medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.

(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services must, at a minimum, meet the following criteria:

1. The entity must be licensed by the Department of Insurance under part II of chapter 641.

2. The entity must be experienced in providing outpatient specialty services.

3. The entity must demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.

4. The entity must demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients enrolled in the pilot managed care program to resolve complaints and grievances.

(b) The pilot managed care program shall operate for a period of 3 years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient

specialty services to Medicaid recipients on a prepaid, capitated basis.

(c) The agency shall conduct a quality assurance review of the prepaid health clinic each year that the demonstration program is in effect. The prepaid health clinic is responsible for all expenses incurred by the agency in conducting a quality assurance review.

(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).

(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.

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

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

1. Medicaid prescribed-drug coverage for brand-name drugs for adult Medicaid recipients ~~not residing in nursing homes or other institutions~~ is limited to the dispensing of four brand-name drugs per month per recipient. Children ~~and institutionalized adults~~ are exempt from this restriction. Antiretroviral agents are excluded from this limitation. No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may be imposed on Medicaid recipients. Medications that will be

available without restriction for persons with mental illnesses include atypical antipsychotic medications, conventional antipsychotic medications, selective serotonin reuptake inhibitors, and other medications used for the treatment of serious mental illnesses. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply. The agency shall continue to provide unlimited generic drugs, contraceptive drugs and items, and diabetic supplies. The agency may authorize exceptions to the brand-name-drug restriction 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.; and

c. Except for the exception for nursing home residents and other institutionalized adults and except for drugs on the restricted formulary for which prior authorization may be sought by an institutional or community pharmacy, prior authorization for an exception to the brand-name-drug restriction is sought by the prescriber and not by the pharmacy. When prior authorization is granted for a patient in an institutional setting beyond the brand-name-drug restriction, such approval is authorized for 12 months and monthly prior authorization is not required for that patient.

1 2. Reimbursement to pharmacies for Medicaid prescribed
2 drugs shall be set at the average wholesale price less 13.25
3 percent.
4 3. The agency shall develop and implement a process
5 for managing the drug therapies of Medicaid recipients who are
6 using significant numbers of prescribed drugs each month. The
7 management process may include, but is not limited to,
8 comprehensive, physician-directed medical-record reviews,
9 claims analyses, and case evaluations to determine the medical
10 necessity and appropriateness of a patient's treatment plan
11 and drug therapies. The agency may contract with a private
12 organization to provide drug-program-management services. The
13 Medicaid drug benefit management program shall include
14 initiatives to manage drug therapies for HIV/AIDS patients,
15 patients using 20 or more unique prescriptions in a 180-day
16 period, and the top 1,000 patients in annual spending.
17 4. The agency may limit the size of its pharmacy
18 network based on need, competitive bidding, price
19 negotiations, credentialing, or similar criteria. The agency
20 shall give special consideration to rural areas in determining
21 the size and location of pharmacies included in the Medicaid
22 pharmacy network. A pharmacy credentialing process may include
23 criteria such as a pharmacy's full-service status, location,
24 size, patient educational programs, patient consultation,
25 disease-management services, and other characteristics. The
26 agency may impose a moratorium on Medicaid pharmacy enrollment
27 when it is determined that it has a sufficient number of
28 Medicaid-participating providers.
29 5. The agency shall develop and implement a program
30 that requires Medicaid practitioners who prescribe drugs to
31 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 35 percent and the agency determines the product competitive. The agency may determine that specific generic products are competitive at lower rebate percentages.

8. The agency shall establish an advisory committee for the purposes of studying the feasibility of using a restricted drug formulary for nursing home residents and other

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1 institutionalized adults. The committee shall be comprised of
2 seven members appointed by the Secretary of Health Care
3 Administration. The committee members shall include two
4 physicians licensed under chapter 458 or chapter 459, Florida
5 Statutes; three pharmacists licensed under chapter 465,
6 Florida Statutes, and appointed from a list of recommendations
7 provided by the Florida Long-Term Care Pharmacy Alliance; and
8 two pharmacists licensed under chapter 465, Florida Statutes.
9 (b) The agency shall implement this subsection to the
10 extent that funds are appropriated to administer the Medicaid
11 prescribed-drug spending-control program. The agency may
12 contract all or any part of this program to private
13 organizations.
14 (c) The agency shall submit a report to the Governor,
15 the President of the Senate, and the Speaker of the House of
16 Representatives by January 15 of each year. The report must
17 include, but need not be limited to, the progress made in
18 implementing Medicaid cost-containment measures and their
19 effect on Medicaid prescribed-drug expenditures.
20 (38) Notwithstanding the provisions of chapter 287,
21 the agency may, at its discretion, renew a contract or
22 contracts for fiscal intermediary services one or more times
23 for such periods as the agency may decide; however, all such
24 renewals may not combine to exceed a total period longer than
25 the term of the original contract.
26 (39) The agency shall provide for the development of a
27 demonstration project by establishment in Miami-Dade County of
28 a long-term-care facility licensed pursuant to chapter 395 to
29 improve access to health care for a predominantly minority,
30 medically underserved, and medically complex population and to
31 evaluate alternatives to nursing-home care and general acute

1 care for such population. Such project is to be located in a
2 health care condominium and colocated with licensed facilities
3 providing a continuum of care. The establishment of this
4 project is not subject to the provisions of s. 408.036 or s.
5 408.039. The agency shall report its findings to the
6 Governor, the President of the Senate, and the Speaker of the
7 House of Representatives by January 1, 2003.
8 Section 10. Paragraphs (f) and (k) of subsection (2)
9 of section 409.9122, Florida Statutes, are amended to read:
10 409.9122 Mandatory Medicaid managed care enrollment;
11 programs and procedures.--
12 (2)
13 (f) When a Medicaid recipient does not choose a
14 managed care plan or MediPass provider, the agency shall
15 assign the Medicaid recipient to a managed care plan or
16 MediPass provider. Medicaid recipients who are subject to
17 mandatory assignment but who fail to make a choice shall be
18 assigned to managed care plans or provider service networks
19 until an equal enrollment of 50 percent in MediPass and
20 provider service networks and 50 percent in managed care plans
21 is achieved. Once equal enrollment is achieved, the
22 assignments shall be divided in order to maintain an equal
23 enrollment in MediPass and managed care plans ~~for the~~
24 ~~1998-1999 fiscal year~~. Thereafter, assignment of Medicaid
25 recipients who fail to make a choice shall be based
26 proportionally on the preferences of recipients who have made
27 a choice in the previous period. Such proportions shall be
28 revised at least quarterly to reflect an update of the
29 preferences of Medicaid recipients. The agency shall also
30 disproportionately assign Medicaid-eligible children in
31 families who are required to but have failed to make a choice

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1 of managed-care plan or MediPass for their child and who are
2 to be assigned to the MediPass program to children's networks
3 as described in s. 409.912(3)(g) and where available. The
4 disproportionate assignment of children to children's networks
5 shall be made until the agency has determined that the
6 children's networks have sufficient numbers to be economically
7 operated.When making assignments, the agency shall take into
8 account the following criteria:
9 1. A managed care plan has sufficient network capacity
10 to meet the need of members.
11 2. The managed care plan or MediPass has previously
12 enrolled the recipient as a member, or one of the managed care
13 plan's primary care providers or MediPass providers has
14 previously provided health care to the recipient.
15 3. The agency has knowledge that the member has
16 previously expressed a preference for a particular managed
17 care plan or MediPass provider as indicated by Medicaid
18 fee-for-service claims data, but has failed to make a choice.
19 4. The managed care plan's or MediPass primary care
20 providers are geographically accessible to the recipient's
21 residence.
22 (k)~~1. Notwithstanding the provisions of paragraph (f),~~
23 ~~and for the 2000-2001 fiscal year only,~~When a Medicaid
24 recipient does not choose a managed care plan or MediPass
25 provider, the agency shall assign the Medicaid recipient to a
26 managed care plan, except in those counties in which there are
27 fewer than two managed care plans accepting Medicaid
28 enrollees, in which case assignment shall be to a managed care
29 plan or a MediPass provider. Medicaid recipients in counties
30 with fewer than two managed care plans accepting Medicaid
31 enrollees who are subject to mandatory assignment but who fail

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1 to make a choice shall be assigned to managed care plans until
2 an equal enrollment of 50 percent in MediPass and provider
3 service networks and 50 percent in managed care plans is
4 achieved. Once equal enrollment is achieved, the assignments
5 shall be divided in order to maintain an equal enrollment in
6 MediPass and managed care plans. When making assignments, the
7 agency shall take into account the following criteria:
8 1.~~a.~~ A managed care plan has sufficient network
9 capacity to meet the need of members.
10 2.~~b.~~ The managed care plan or MediPass has previously
11 enrolled the recipient as a member, or one of the managed care
12 plan's primary care providers or MediPass providers has
13 previously provided health care to the recipient.
14 3.~~c.~~ The agency has knowledge that the member has
15 previously expressed a preference for a particular managed
16 care plan or MediPass provider as indicated by Medicaid
17 fee-for-service claims data, but has failed to make a choice.
18 4.~~d.~~ The managed care plan's or MediPass primary care
19 providers are geographically accessible to the recipient's
20 residence.
21 5.~~e.~~ The agency has authority to make mandatory
22 assignments based on quality of service and performance of
23 managed care plans.
24 ~~2. This paragraph is repealed on July 1, 2001.~~
25 Section 11. Paragraph (a) of subsection (1) and
26 subsection (7) of section 409.915, Florida Statutes, are
27 amended to read:
28 409.915 County contributions to Medicaid.--Although
29 the state is responsible for the full portion of the state
30 share of the matching funds required for the Medicaid program,
31 in order to acquire a certain portion of these funds, the

1 state shall charge the counties for certain items of care and
2 service as provided in this section.
3 (1) Each county shall participate in the following
4 items of care and service:
5 (a) <u>For both health maintenance members and</u>
6 <u>fee-for-service beneficiaries,</u>payments for inpatient
7 hospitalization in excess of <u>10</u> ~~12~~ days, but not in excess of
8 45 days, with the exception of pregnant women and children
9 whose income is in excess of the federal poverty level and who
10 do not participate in the Medicaid medically needy program.
11 (7) <u>Counties are exempt from contributing toward the</u>
12 <u>cost of new exemptions on inpatient ceilings for statutory</u>
13 <u>teaching hospitals, specialty hospitals, and community</u>
14 <u>hospital education program hospitals that came into effect</u>
15 <u>July 1, 2000, and for special Medicaid payments that came into</u>
16 <u>effect on or after July 1, 2000.</u>~~Notwithstanding any provision~~
17 ~~of this section to the contrary, counties are exempt from~~
18 ~~contributing toward the increased cost of hospital inpatient~~
19 ~~services due to the elimination of ceilings on Medicaid~~
20 ~~inpatient reimbursement rates paid to teaching hospitals,~~
21 ~~specialty hospitals, and community health education program~~
22 ~~hospitals and for special Medicaid reimbursements to hospitals~~
23 ~~for which the Legislature has specifically appropriated funds.~~
24 ~~This subsection is repealed on July 1, 2001.~~
25 Section 12. <u>Effective upon this act becoming a law,</u>
26 <u>and notwithstanding sections 409.911, 409.9113, and 409.9117,</u>
27 <u>Florida Statutes, from the funds made available under the</u>
28 <u>Medicare program, the Medicaid program, and the State</u>
29 <u>Children's Health Insurance Program Benefits Improvement and</u>
30 <u>Protection Act of 2000 for the 2001 federal fiscal year,</u>
31 <u>disproportionate share program funds shall be distributed as</u>

1 follows: $13,937,997 to Jackson Memorial; $285,298 to Mount
2 Sinai Medical Center; $313,748 to Orlando Regional Medical
3 Center; $2,734,019 to Shands - Jacksonville; $1,060,047 to
4 Shands - University of Florida; $1,683,415 to Tampa General
5 Hospital; and $2,231,910 to North Broward Hospital District.
6 Such funds shall be made available in accordance with a budget
7 amendment and the Medicaid plan amendment submitted prior to
8 the close of the 2001 federal fiscal year. This section does
9 not delay implementation of the budget amendment or the
10 Medicaid plan amendment if such is deemed necessary.
11 Section 13. Except as otherwise expressly provided in
12 this act, this act shall take effect July 1, 2001.
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STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
CS/SB 792

Restores the Medicaid income eligibility level for the elderly and disabled to 100 percent of the federal poverty level.

Revises Medicaid eligibility related to cancer treatment for women to allow women under age 65 that have been screened through the National Breast and Cervical Cancer Early Detection program to be eligible.

Extends eligibility to certain disabled persons with incomes under 250 percent of poverty who return to work and would not otherwise qualify to be eligible for Medicaid under a Medicaid Buy-in program.

Clarifies procedures for prior authorization for nonemergency hospital inpatient admissions and authorizes the discontinuance of the hospital retrospective review program.

Removes language related to intermediate care services.

Adds assistive-care services as an optional Medicaid service.

Transfers the Community Hospital Education Program (CHEP) to the Department of Health. Provides that the agency may certify local governmental funds as match to the Medicaid program.

Prohibits increases in patient care or operating components of reimbursement rates to nursing homes or licensed operators for changes in ownership filed on or after October 1, 2001.

Removes competitive bidding from reimbursement for prescribed drugs.

Authorizes the agency to request and implement Medicaid waivers to advance and treat a portion of the Medicaid nursing home per diem as capital for creating and operating a risk-retention group for self-insurance purposes.

Substantially rewords section 409.91195, F.S., that creates the Medicaid Pharmaceutical and Therapeutics Committee and requires the committee to develop a preferred drug formulary and prior authorization program for prescriptions for Medicaid patients. Provides for the membership, duties, and procedures of the committee and prior authorization procedures.

Authorizes the agency to establish prior authorization requirements for certain Medicaid populations, drug classes, and other criteria. Requires the committee to make recommendations to the agency on drugs which prior authorization is required.

Clarifies an exception to the prior authorization process for brand name drug restrictions for nursing home residents and other institutionalized adults which allows an institutional or community pharmacy to request the pror authorization approval.

1 Provides that the Medicaid drug benefit management program shall include drug therapies for HIV/AIDS patients under
2 certain circumstances.

3 Revises the restricted-drug formulary and authorizes negotiations for supplemental rebates from manufacturers at no
4 less than 10 percent of the AWP on the last day of the quarter unless the federal or supplemental rebate, or both, exceeds 35
5 percent and the agency determines the product competitive.

6 Requires the agency to establish a seven member advisory committee to study the feasibility of using a restricted drug
7 formulary for nursing home residents and other other institutionalized adults.
8
Authorizes a demonstration project in Miami-Dade County to
9 establish along term care facility to improve access to health care for a predominately minority, medically underserved, and
10 medically complex population.

11 Continues current law regarding the assignment of Medicaid recipients who do not make a choice of manage care plans.
12
Removes the pilot program to prevent Medicaid fraud and abuse
13 by using a type of automated fingerprint imaging of Medicaid beneficiaries.
14
Provides for the allocation of additional federal
15 disproportionate share funds to certain hospitals and authorizes the submission of a budget amendment prior to the
16 close of federal fiscal year 2000.

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