By Senator Peaden

2-2587-03

A bill to be entitled

An act relating to health care; amending s. 400.179, F.S.; deleting a repeal of provisions requiring payment of certain fees upon the transfer of the leasehold license for a nursing facility; amending s. 400.23, F.S.; delaying the effective date of certain requirements concerning hours of direct care per resident for nursing home facilities; amending s. 409.901, F.S.; defining the term "third party" to include a third-party administrator or pharmacy benefits manager; amending s. 409.904, F.S.; revising provisions governing the payment of optional medical benefits for certain Medicaid-eligible persons; amending s. 409.906, F.S.; deleting provisions authorizing payment for adult dental services; revising requirements for hearing and visual services to limit such services to persons younger than 21 years of age; amending s. 409.908, F.S., relating to reimbursement of Medicaid providers; providing for a fee to be paid to providers returning unused medications and credited to the Medicaid program; conforming a cross-reference; amending s. 409.9081, F.S.; providing a copayment under the Medicaid program for certain nonemergency hospital visits; amending ss. 409.911, 409.9112, 409.9116, and 409.9117, F.S.; revising the disproportionate share program; deleting definitions; requiring the Agency for Health

Care Administration to use actual audited data to determine the Medicaid days and charity care to be used to calculate the disproportionate share payment; revising formulas for calculating payments; revising the formula for calculating payments under the disproportionate share program for regional perinatal intensive care centers; providing for estimates of the payments under the rural disproportionate share and financial assistance programs; providing a formula for calculating payments under the primary care disproportionate share program; repealing s. 409.9119, F.S., relating to disproportionate share program for specialty hospitals for children; amending s. 409.912, F.S.; providing for reimbursement of provider service networks; removing certain requirements for prior authorization for nursing home residents and institutionalized adults; prohibiting value-added rebates to a pharmaceutical manufacturer; deleting provisions authorizing certain benefits in conjunction with supplemental rebates; authorizing the agency to implement a utilization management program for certain services; amending s. 409.9122, F.S.; revising the percentage of Medicaid recipients required to be enrolled in managed care; providing for construction of the act in pari materia with laws enacted during the Regular Session of the Legislature; providing an effective date.

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

Section 1. Effective upon this act becoming a law, paragraph (d) of subsection (5) of section 400.179, Florida Statutes, is amended to read:

400.179 Sale or transfer of ownership of a nursing facility; liability for Medicaid underpayments and overpayments.--

(5) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

(d) Where the transfer involves a facility that has been leased by the transferor:

1. The transferee shall, as a condition to being issued a license by the agency, acquire, maintain, and provide proof to the agency of a bond with a term of 30 months, renewable annually, in an amount not less than the total of 3 months Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid at the time of any subsequent annual license renewal, in the amount of 2 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not

available, projected Medicaid payments may be used. The fee shall be deposited into the Health Care Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and management of this account, including withdrawals from the account, subject to federal review and approval. ~~This subparagraph is repealed on June 30, 2003.~~This provision shall take effect upon becoming law and shall apply to any leasehold license application.

a. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits.

b. The agency, in consultation with the Florida Health Care Association and the Florida Association of Homes for the Aging, shall study and make recommendations on the minimum amount to be held in reserve to protect against Medicaid overpayments to leasehold licensees and on the issue of successor liability for Medicaid overpayments upon sale or transfer of ownership of a nursing facility. The agency shall

submit the findings and recommendations of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

3. The leasehold licensee may meet the bond requirement through other arrangements acceptable to the agency. The agency is herein granted specific authority to promulgate rules pertaining to lease bond arrangements.

4. All existing nursing facility licensees, operating the facility as a leasehold, shall acquire, maintain, and provide proof to the agency of the 30-month bond required in subparagraph 1., above, on and after July 1, 1993, for each license renewal.

5. It shall be the responsibility of all nursing facility operators, operating the facility as a leasehold, to renew the 30-month bond and to provide proof of such renewal to the agency annually at the time of application for license renewal.

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, cancel, revoke, or suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

Section 2. Paragraph (a) of subsection (3) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.--

(3)(a) The agency shall adopt rules providing for the minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning January 1, 2003, and increasing to 2.9 hours of direct care per resident per day beginning July ~~January~~ 1, 2004. Beginning January 1, 2002, no facility shall staff below one certified nursing assistant per 20 residents, and a minimum licensed nursing staffing of 1.0 hour of direct resident care per resident per day but never below one licensed nurse per 40 residents. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants only if they provide nursing assistance services to residents on a full-time basis. Each nursing home must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses so recognized are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted towards the minimum staffing requirements for certified

nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and shall not also be counted towards the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

Section 3. Subsection (25) of section 409.901, Florida Statutes, is amended to read:

409.901 Definitions; ss. 409.901-409.920.--As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(25) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid. A third party includes a third-party administrator or a pharmacy benefits manager.

Section 4. Subsection (2) of section 409.904, Florida Statutes, as amended by section 1 of chapter 2003-9, Laws of Florida, is amended to read:

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment

on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(2) A family ~~caretaker relative or parent~~, a pregnant woman, a child under age 21 ~~19 who would otherwise qualify for Florida Kidcare Medicaid, a child up to age 21 who would otherwise qualify under s. 409.903(1)~~, a person age 65 or over, or a blind or disabled person, who would ~~otherwise~~ be eligible under any group listed in s. 409.903(1), (2), or (3) ~~for Florida Medicaid~~, except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. ~~Expenses used to meet spend-down liability are not reimbursable by Medicaid. Effective July 1, 2003, when determining the eligibility of a pregnant woman, a child, or an aged, blind, or disabled individual, $270 shall be deducted from the countable income of the filing unit. When determining the eligibility of the parent or caretaker relative as defined by Title XIX of the Social Security Act, the additional income disregard of $270 does not apply.~~A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 5. Section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for

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

~~(1) ADULT DENTAL SERVICES.--The agency may pay for medically necessary, emergency dental procedures to alleviate pain or infection. Emergency dental care shall be limited to emergency oral examinations, necessary radiographs, extractions, and incision and drainage of abscess, for a recipient who is age 21 or older. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:~~

~~(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with~~

~~Medicaid's county health department clinic services program specifications as a county health department clinic services provider.~~

~~(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.~~

~~(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.~~

~~(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.~~

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

(2)~~(3)~~ AMBULATORY SURGICAL CENTER SERVICES.--The agency may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395, by or under the direction of a licensed physician or dentist.

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

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

(5)~~(6)~~ CHILDREN'S DENTAL SERVICES.--The agency may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

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

(7)~~(8)~~ COMMUNITY MENTAL HEALTH SERVICES.--

(a) The agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider under contract with the agency or the Department of Children and Family Services to provide such services. Those services which are psychiatric in nature shall be rendered or recommended by a psychiatrist, and those services which are medical in nature shall be rendered or recommended by a physician or psychiatrist. The agency must develop a provider enrollment process for community mental health providers which bases provider enrollment on an assessment of service need. The provider enrollment process shall be designed to control costs, prevent fraud and abuse, consider provider expertise and capacity, and assess provider success in managing utilization of care and measuring treatment outcomes. Providers will be selected through a competitive procurement or selective contracting process. In addition to other

community mental health providers, the agency shall consider for enrollment mental health programs licensed under chapter 395 and group practices licensed under chapter 458, chapter 459, chapter 490, or chapter 491. The agency is also authorized to continue operation of its behavioral health utilization management program and may develop new services if these actions are necessary to ensure savings from the implementation of the utilization management system. The agency shall coordinate the implementation of this enrollment process with the Department of Children and Family Services and the Department of Juvenile Justice. The agency is authorized to utilize diagnostic criteria in setting reimbursement rates, to preauthorize certain high-cost or highly utilized services, to limit or eliminate coverage for certain services, or to make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(b) The agency is authorized to implement reimbursement and use management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization of treatment and service plans; prior authorization of services; enhanced use review programs for highly used services; and limits on services for those determined to be abusing their benefit coverages.

(8)~~(9)~~ DIALYSIS FACILITY SERVICES.--Subject to specific appropriations being provided for this purpose, the agency may pay a dialysis facility that is approved as a dialysis facility in accordance with Title XVIII of the Social Security Act, for dialysis services that are provided to a Medicaid recipient under the direction of a physician licensed

to practice medicine or osteopathic medicine in this state, including dialysis services provided in the recipient's home by a hospital-based or freestanding dialysis facility.

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

(10)~~(11)~~ HEALTHY START SERVICES.--The agency may pay for a continuum of risk-appropriate medical and psychosocial services for the Healthy Start program in accordance with a federal waiver. The agency may not implement the federal waiver unless the waiver permits the state to limit enrollment or the amount, duration, and scope of services to ensure that expenditures will not exceed funds appropriated by the Legislature or available from local sources. If the Health Care Financing Administration does not approve a federal waiver for Healthy Start services, the agency, in consultation with the Department of Health and the Florida Association of Healthy Start Coalitions, is authorized to establish a Medicaid certified-match program for Healthy Start services. Participation in the Healthy Start certified-match program shall be voluntary, and reimbursement shall be limited to the federal Medicaid share to Medicaid-enrolled Healthy Start coalitions for services provided to Medicaid recipients. The agency shall take no action to implement a certified-match program without ensuring that the amendment and review requirements of ss. 216.177 and 216.181 have been met.

(11)~~(12)~~ CHILDREN'S HEARING SERVICES.--The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient younger

than 21 years of age by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(12)~~(13)~~ HOME AND COMMUNITY-BASED SERVICES.--The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program. The agency may limit or eliminate coverage for certain Project AIDS Care Waiver services, preauthorize high-cost or highly utilized services, or make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

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

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

(15)~~(16)~~ INTERMEDIATE CARE SERVICES.--The agency may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part II of chapter 400, if the services are ordered by and provided under the direction of a physician.

(16)~~(17)~~ OPTOMETRIC SERVICES.--The agency may pay for services provided to a recipient, including examination,

diagnosis, treatment, and management, related to ocular pathology, if the services are provided by a licensed optometrist or physician.

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

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

(19)~~(20)~~ PRESCRIBED DRUG SERVICES.--The agency may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

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

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

(22)~~(23)~~ CHILDREN'S VISUAL SERVICES.--The agency may pay for visual examinations, eyeglasses, and eyeglass repairs

for a recipient younger than 21 years of age, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

(23)~~(24)~~ CHILD-WELFARE-TARGETED CASE MANAGEMENT.--The Agency for Health Care Administration, in consultation with the Department of Children and Family Services, may establish a targeted case-management project in those counties identified by the Department of Children and Family Services and for all counties with a community-based child welfare project, as authorized under s. 409.1671, which have been specifically approved by the department. Results of targeted case management projects shall be reported to the Social Services Estimating Conference established under s. 216.136. The covered group of individuals who are eligible to receive targeted case management include children who are eligible for Medicaid; who are between the ages of birth through 21; and who are under protective supervision or postplacement supervision, under foster-care supervision, or in shelter care or foster care. The number of individuals who are eligible to receive targeted case management shall be limited to the number for whom the Department of Children and Family Services has available matching funds to cover the costs. The general revenue funds required to match the funds for services provided by the community-based child welfare projects are limited to funds available for services described under s. 409.1671. The Department of Children and Family Services may transfer the general revenue matching funds as billed by the Agency for Health Care Administration.

(24)~~(25)~~ ASSISTIVE-CARE SERVICES.--The agency may pay for assistive-care services provided to recipients with functional or cognitive impairments residing in assisted

living facilities, adult family-care homes, or residential treatment facilities. These services may include health support, assistance with the activities of daily living and the instrumental acts of daily living, assistance with medication administration, and arrangements for health care.

Section 6. Subsections (14) and (20) of section 409.908, Florida Statutes, are amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be affected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates,

lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(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, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred-drug-list products. The agency may ~~shall~~ increase the pharmacy dispensing fee authorized by statute and in the annual General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred-drug list. The agency may establish a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications to stock and crediting the Medicaid program for the ingredient cost of those medications if the ingredient costs to be credited exceed the value of the supplemental dispensing fee.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.

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

Section 7. Subsection (1) of section 409.9081, Florida Statutes, is amended to read:

409.9081 Copayments.--

(1) The agency shall require, subject to federal regulations and limitations, each Medicaid recipient to pay at the time of service a nominal copayment for the following Medicaid services:

(a) Hospital outpatient services: up to $3 for each hospital outpatient visit.

(b) Physician services: up to $2 copayment for each visit with a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463.

(c) Hospital emergency department visits for nonemergency care: $15 for each emergency department visit.

Section 8. Section 409.911, Florida Statutes, is 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, s. 409.9112, and the Florida Hospital Uniform Reporting System manual:

(a) "Adjusted patient days" means the sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(b) "Actual audited data" or "actual audited experience" means data reported to the Agency for Health Care Administration which has been audited in accordance with generally accepted auditing standards by the agency or representatives under contract with the agency.

~~(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. The base Medicaid per diem rate shall not include any additional per diem increases received as a result of the disproportionate share distribution.~~

(c)~~(d)~~ "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges

due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.

(d)~~(e)~~ "Charity care days" means the sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

~~(f) "Disproportionate share percentage" means a rate of increase in the Medicaid per diem rate as calculated under this section.~~

(e)~~(g)~~ "Hospital" means a health care institution licensed as a hospital pursuant to chapter 395, but does not include ambulatory surgical centers.

(f)~~(h)~~ "Medicaid days" means the number of actual days attributable to Medicaid patients as determined by the Agency for Health Care Administration.

(2) The Agency for Health Care Administration shall use ~~utilize~~ the following actual audited data ~~criteria~~ to determine the Medicaid days and charity care to be used in calculating the ~~if a hospital qualifies for a~~ disproportionate share payment:

(a) The average of the 1997, 1998, and 1999 audited data to determine each hospital's Medicaid days and charity care.

(b) The average of the audited disproportionate share data for the years available if the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share data for a hospital.

~~(a) A hospital's total Medicaid days when combined with its total charity care days must equal or exceed 7 percent of its total adjusted patient days.~~

~~(b) A hospital's total charity care days weighted by a factor of 4.5, plus its total Medicaid days weighted by a factor of 1, shall be equal to or greater than 10 percent of its total adjusted patient days.~~

(c) ~~Additionally,~~In accordance with s. 1923(b) of the Social Security Act ~~the seventh federal Omnibus Budget Reconciliation Act~~, a hospital with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater shall qualify for reimbursement.

~~(3) In computing the disproportionate share rate:~~

~~(a) Per diem increases earned from disproportionate share shall be applied to each hospital's base Medicaid per diem rate and shall be capped at 170 percent.~~

~~(b) The agency shall use 1994 audited financial data for the calculation of disproportionate share payments under this section.~~

~~(c) If the total amount earned by all hospitals under this section exceeds the amount appropriated, each hospital's share shall be reduced on a pro rata basis so that the total dollars distributed from the trust fund do not exceed the total amount appropriated.~~

~~(d) The total amount calculated to be distributed under this section shall be made in quarterly payments subsequent to each quarter during the fiscal year.~~

(3)~~(4)~~ Hospitals that qualify for a disproportionate share payment solely under paragraph (2)(c) shall have their payment calculated in accordance with the following formulas:

DSHP = (HMD/TMSD)*$1 million

Where:

DSHP = disproportionate share hospital payment.
HMD = hospital Medicaid days.
TSD = total state Medicaid days.

~~TAA = TA x (1/5.5)~~
~~DSHP = (HMD/TSMD) x TAA~~

~~Where:~~
~~TAA = total amount available.~~
~~TA = total appropriation.~~
~~DSHP = disproportionate share hospital payment.~~
~~HMD = hospital Medicaid days.~~
~~TSMD = total state Medicaid days.~~

(4) The following formulas shall be used to pay disproportionate share dollars to public hospitals:

(a) For state mental health hospitals:

DSHP = (HMD/TMDMH) * TAAMH

shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program.

Where:

DSHP = disproportionate share hospital payment.
HMD = hospital Medicaid days.
TMDHH = total Medicaid days for state mental health hospitals.
TAAMH = total amount available for mental health hospitals.

(b) For non-state government owned or operated hospitals with 3,300 or more Medicaid days:

DSHP = [(.82*HCCD/TCCD) + (.18*HMD/TMD)] * TAAPH
TAAPH = TAA - TAAMH

Where:

TAA = total available appropriation.
TAAPH = total amount available for public hospitals.
DSHP = disproportionate share hospital payments.
HMD = hospital Medicaid days.
TMD = total state Medicaid days for public hospitals.
HCCD = hospital charity care dollars.
TCCD = total state charity care dollars for public non-state hospitals.

(c) For non-state government owned or operated hospitals with less than 3,300 Medicaid days, a total of $400,000 shall be distributed equally among these hospitals.

~~(5) The following formula shall be utilized by the agency to determine the maximum disproportionate share rate to~~

~~be used to increase the Medicaid per diem rate for hospitals that qualify pursuant to paragraphs (2)(a) and (b):~~al>

$$DSR = \left(\frac{CCD}{APD} \times 4.5\right) + \frac{MD}{APD}$$

~~Where:~~

~~APD = adjusted patient days.~~

~~CCD = charity care days.~~

~~DSR = disproportionate share rate.~~

~~MD = Medicaid days.~~

~~(6)(a) To calculate the total amount earned by all hospitals under this section, hospitals with a disproportionate share rate less than 50 percent shall divide their Medicaid days by four, and hospitals with a disproportionate share rate greater than or equal to 50 percent and with greater than 40,000 Medicaid days shall multiply their Medicaid days by 1.5, and the following formula shall be used by the agency to calculate the total amount earned by all hospitals under this section:~~

$$TAE = BMPD \times MD \times DSP$$

~~Where:~~

~~TAE = total amount earned.~~

~~BMPD = base Medicaid per diem.~~

~~MD = Medicaid days.~~

~~DSP = disproportionate share percentage.~~

(5)~~(b)~~ In no case shall total payments to a hospital under this section, with the exception of public non-state facilities or state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the agency according to the most recent calendar year audited data available at the beginning of each state fiscal year.

~~(7) The following criteria shall be used in determining the disproportionate share percentage:~~

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

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

~~(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.~~

~~(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.~~

~~(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.~~

~~(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.~~

~~(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.~~

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

~~(8) The following formula shall be used by the agency to calculate the total amount earned by all hospitals under this section:~~

~~TAE = BMPD x MD x DSP~~

~~Where:~~

~~TAE = total amount earned.~~

~~BMPD = base Medicaid per diem.~~

~~MD = Medicaid days.~~

~~DSP = disproportionate share percentage.~~

(6)~~(9)~~ The agency is authorized to receive funds from local governments and other local political subdivisions for the purpose of making payments, including federal matching funds, through the Medicaid disproportionate share program. Funds received from local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(7)~~(10)~~ Payments made by the agency to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.

(a) If the Federal Government prohibits, restricts, or changes in any manner the methods by which funds are distributed for this program, the agency shall not distribute any additional funds and shall return all funds to the local government from which the funds were received, except as provided in paragraph (b).

(b) If the Federal Government imposes a restriction that still permits a partial or different distribution, the agency may continue to disburse funds to hospitals participating in the disproportionate share program in a federally approved manner, provided:

1. Each local government which contributes to the disproportionate share program agrees to the new manner of distribution as shown by a written document signed by the governing authority of each local government; and

2. The Executive Office of the Governor, the Office of Planning and Budgeting, the House of Representatives, and the Senate are provided at least 7 days' prior notice of the proposed change in the distribution, and do not disapprove such change.

(c) No distribution shall be made under the alternative method specified in paragraph (b) unless all parties agree or unless all funds of those parties that disagree which are not yet disbursed have been returned to those parties.

(8)~~(11)~~ Notwithstanding the provisions of chapter 216, the Executive Office of the Governor is hereby authorized to establish sufficient trust fund authority to implement the disproportionate share program.

Section 9. Section 409.9112, Florida Statutes, is amended to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center

program established pursuant to chapter 383. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. 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) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the regional perinatal intensive care center program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a regional perinatal intensive care center.

HDSP = the prior state fiscal year regional perinatal intensive care center disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total regional perinatal intensive care center disproportionate share payments to all hospitals.

(2) The total additional payment for hospitals that participate in the regional perinatal intensive care center program shall be calculated by the agency as follows:

TAP = TAE * TA

Where:

TAP = total additional payment for a regional perinatal intensive care center.

TAE = total amount earned by a regional perinatal intensive care center.

TA = total appropriation for the regional perinatal intensive care center disproportionate share program.

~~TAE = DSR x BMPD x MD~~

~~Where:~~

~~TAE = total amount earned by a regional perinatal intensive care center.~~

~~DSR = disproportionate share rate.~~

~~BMPD = base Medicaid per diem.~~

~~MD = Medicaid days.~~

~~(2) The total additional payment for hospitals that participate in the regional perinatal intensive care center program shall be calculated by the agency as follows:~~

$$\text{TAP} = \left(\frac{\text{TAE} \times \text{TA}}{\text{STAE}}\right)$$

~~Where:~~

~~TAP = total additional payment for a regional perinatal intensive care center.~~

~~TAE = total amount earned by a regional perinatal intensive care center.~~

~~STAE = sum of total amount earned by each hospital that participates in the regional perinatal intensive care center program.~~

~~TA = total appropriation for the regional perinatal intensive care disproportionate share program.~~

(3) In order to receive payments under this section, a hospital must be participating in the regional perinatal intensive care center program pursuant to chapter 383 and must meet the following additional requirements:

(a) Agree to conform to all departmental and agency requirements to ensure high quality in the provision of services, including criteria adopted by departmental and agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department and agency deem appropriate as specified by rule.

(b) Agree to provide information to the department and agency, in a form and manner to be prescribed by rule of the department and agency, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

(c) Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

(d) Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

(e) Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

(f) Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

(g) Agree to provide backup and referral services to the department's county health departments and other low-income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

(h) Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

(4) Hospitals which fail to comply with any of the conditions in subsection (3) or the applicable rules of the department and agency shall not receive any payments under this section until full compliance is achieved. A hospital which is not in compliance in two or more consecutive quarters shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating regional perinatal intensive care center program hospitals.

Section 10. Subsection (1) of section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share/financial assistance program for rural hospitals.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall administer a federally matched disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency shall make

disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. The disproportionate share program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program or the financial assistance program:

TAERH = (CCD + MDD)/TPD

Where:

CCD = total charity care-other, plus charity care-Hill-Burton, minus 50 percent of unrestricted tax revenue from local governments, and restricted funds for indigent care, divided by gross revenue per adjusted patient day; however, if CCD is less than zero, then zero shall be used for CCD.

MDD = Medicaid inpatient days plus Medicaid HMO inpatient days.

TPD = total inpatient days.

TAERH = total amount earned by each rural hospital.

In computing the total amount earned by each rural hospital, the agency must use the average of the 3 most recent years of actual data reported in accordance with s. 408.061(4)(a). The agency shall provide a preliminary estimate of the payments under the rural disproportionate share and financial assistance programs to the rural hospitals by August 31 of each state fiscal year for review. Each rural hospital shall have 30 days to review the preliminary estimates of payments and report any errors to the agency. The agency shall make any corrections deemed necessary and compute the rural disproportionate share and financial assistance program payments.

Section 11. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--

(1) If federal funds are available for disproportionate share programs in addition to those otherwise provided by law, there shall be created a primary care disproportionate share program.

(2) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the primary care disproportionate share program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a hospital participating in the primary care disproportionate share program.

HDSP = the prior state fiscal year primary care disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total primary care disproportionate share payments to all hospitals.

(3) The total additional payment for hospitals that participate in the primary care disproportionate share program shall be calculated by the agency as follows:

TAP = TAE * TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

TA = total appropriation for the primary care disproportionate share program.

(4)~~(2)~~ In the establishment and funding of this program, the agency shall use the following criteria in addition to those specified in s. 409.911, payments may not be made to a hospital unless the hospital agrees to:

(a) Cooperate with a Medicaid prepaid health plan, if one exists in the community.

(b) Ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level who are not

otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.

(d) Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

(e) Cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

(f) In cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area.

(g) Provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do

not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay.

(h) Work with the Florida Healthy Kids Corporation, the Florida Health Care Purchasing Cooperative, and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.

(i) Work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services.

(j) Work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until full compliance is achieved.

Section 12. Section 409.9119, Florida Statutes, is repealed.

Section 13. Paragraph (d) of subsection (3) and paragraph (a) of subsection (38) of section 409.912, Florida Statutes, are amended, and subsection (41) is added to that section, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may establish prior authorization requirements for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization.

(3) The agency may contract with:

(d) A provider service network ~~No more than four provider service networks for 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 years from the date of implementation.~~

(38)(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 is limited to the dispensing of four brand-name drugs per month per recipient. Children 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. Although a drug may be included on the preferred drug formulary, it would not be exempt from the four-brand limit. 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;

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.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews,

claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending.

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

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

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid

recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and 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 a quarter unless the federal or supplemental rebate, or both, equals or exceeds 25 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the

purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Effective July 1, 2003, value-added programs as a substitution for supplemental rebates are prohibited.~~Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act.~~The agency is authorized to seek any federal waivers to implement this initiative.

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 institutionalized adults. The committee shall be comprised of seven members appointed by the Secretary of Health Care Administration. The committee members shall include two physicians licensed under chapter 458 or chapter 459; three pharmacists licensed under chapter 465 and appointed from a list of recommendations provided by the Florida Long-Term Care Pharmacy Alliance; and two pharmacists licensed under chapter 465.

9. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid

recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

(41) The agency shall develop and implement a utilization management program for Medicaid-eligible recipients younger than 21 years of age for the management of occupational, physical, respiratory, and speech therapies. The agency shall establish a utilization program that may require prior authorization in order to ensure medically necessary and cost-effective treatments. The program shall be operated in accordance with a federally approved waiver program or state plan amendment. The agency may seek a federal waiver or state plan amendment to implement this program. The agency may also competitively procure these services from an outside vendor on a regional or statewide basis.

Section 14. Paragraphs (f) and (k) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 ~~45~~ percent in MediPass and 60 ~~55~~ percent in managed care plans is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in

MediPass and managed care plans which is in a 40 ~~45~~ percent and 60 ~~55~~ percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(3)(g), Children's Medical Services network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. Beginning July 1, 2002, the agency shall assign all children in families who have not made a choice of a managed care plan or MediPass in the required timeframe to a pediatric emergency room diversion program described in s. 409.912(3)(g) that, as of July 1, 2002, has executed a contract with the agency, until such network or

program has reached an enrollment of 15,000 children. Once that minimum enrollment level has been reached, the agency shall assign children who have not chosen a managed care plan or MediPass to the network or program in a manner that maintains the minimum enrollment in the network or program at not less than 15,000 children. To the extent practicable, the agency shall also assign all eligible children in the same family to such network or program. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice

shall be assigned to managed care plans until an enrollment of 40 ~~45~~ percent in MediPass and 60 ~~55~~ percent in managed care plans is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 40 ~~45~~ percent and 60 ~~55~~ percent proportion, respectively. In geographic areas where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

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

Section 15. Paragraph (q) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.--

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

(q) Dental services.--~~Subject to a specific appropriation for this benefit,~~Covered services include those dental services provided to children by the Florida Medicaid program under s. 409.906(5)<u>, up to a maximum benefit of $500 per enrollee per year</u>.

Section 16. <u>If any law that is amended by this act was also amended by a law enacted at the 2003 Regular Session of the Legislature, such laws shall be construed as if they had been enacted during the same session of the Legislature, and full effect should be given to each if that is possible.</u>

Section 17. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2003.

****

SENATE SUMMARY

Revises various provisions of the Medicaid program. Revises requirements for dental, hearing, and visual services. Deletes certain requirements for prior authorization. Prohibits value-added rebates. Revises the formulas used to calculate payments under the disproportionate share program. (See bill for details.)