A bill to be entitled

An act relating to health care; amending s. 400.23, F.S.; delaying a nursing home staffing increase; amending s. 409.903, F.S.; deleting a provision eliminating eligibility for Medicaid services for certain women; amending s. 409.904, F.S.; providing for the Agency for Health Care Administration to pay for medical assistance for certain Medicaid-eligible persons; deleting a limitation on eligibility for coverage under the medically needy program; amending s. 409.906, F.S.; deleting a repeal of a provision that provides adult denture services; repealing s. 409.9065, F.S., relating to pharmaceutical expense assistance; amending s. 409.908, F.S.; providing for reimbursement of Medicaid providers pursuant to published methodologies; revising provisions relating to the long-term care reimbursement and cost reporting system; revising provisions relating to the Medicaid maximum allowable fee for certain pharmacies; amending s. 409.912, F.S.; revising components of the Medicaid prescribed-drug spending-control program; authorizing the agency to implement a program of all-inclusive care for certain children; amending s. 409.9122, F.S.; deleting assignment requirement for recipients in areas with capitated behavioral health services; amending s. 409.9124, F.S.; requiring the agency to develop managed care rates for children of specified ages and to amend the methodology for reimbursing managed care plans to comply

therewith; limiting the amount of reimbursement; providing effective dates.

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

Section 1. 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 1, 2006 ~~2005~~. 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 toward 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 toward 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 2. Subsection (5) of section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.--The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, determines 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.

(5) A pregnant woman for the duration of her pregnancy and for the postpartum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program. ~~Effective July 1, 2005, eligibility for Medicaid services is eliminated for women who have incomes above 150 percent of the most current federal poverty level.~~

Section 3. Subsections (1) and (2) of section 409.904, Florida Statutes, are 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.

(1)<u>(a) From July 1, 2005, through December 31, 2005, inclusive,</u> a person who is age 65 or older or is determined to

be disabled, whose income is at or below 88 percent of federal poverty level, and whose assets do not exceed established limitations.

(b) Effective January 1, 2006, and subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare, or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care or hospice or home-based and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

(2) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), 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. 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. ~~Effective July 1, 2005, the medically needy are eligible for prescribed drug services only.~~

Section 4. Paragraph (b) of subsection (1) of 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.--

(b) ~~Beginning January 1, 2005,~~ The agency may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is 21 years

of age or older. ~~This paragraph is repealed effective July 1, 2005.~~

Section 5. Effective January 1, 2006, section 409.9065, Florida Statutes, is repealed.

Section 6. Section 409.908, Florida Statutes, is 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 published 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 effected 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. The agency is authorized to adjust ~~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 make ~~making~~ any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

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

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5), except for:

1. The raising of rate reimbursement caps, excluding rural hospitals.

2. Recognition of the costs of graduate medical education.

3. Other methodologies recognized in the General Appropriations Act.

4. Hospital inpatient rates shall be reduced by 6 percent effective July 1, 2001, and restored effective April 1, 2002.

During the years funds are transferred from the Department of Health, any reimbursement supported by such funds shall be subject to certification by the Department of Health that the hospital has complied with s. 381.0403. The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through

the Medicaid inpatient reimbursement methodologies. Funds received from state entities or local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent that the identified local health care provider that is otherwise entitled to and is contracted to receive such local funds is the benefactor under the state's Medicaid program as determined under the General Appropriations Act and pursuant to an agreement between the Agency for Health Care Administration and the local governmental entity. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form shall identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature no later than January 1, annually.

(b) Reimbursement for hospital outpatient care is limited to $1,500 per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

2. Renal dialysis services.

3. Other exceptions made by the agency.

The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, the Board of Regents, local governments, and other local political subdivisions, for the purpose of making payments, including federal matching funds, through the Medicaid outpatient reimbursement methodologies. Funds received from state entities and local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(c) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and the methodologies described in ss. 409.911, 409.9112, and 409.9113.

(d) The agency is authorized to limit inflationary increases for outpatient hospital services as directed by the General Appropriations Act.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under chapter 393 must be made prospectively.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under

part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement must be determined by averaging the nursing home payments, in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(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.

1. Changes of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The agency shall amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.

2. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care and indirect care subcomponents ~~subcomponent~~ of the per diem rate ~~shall be limited by the cost-based class ceiling, and the indirect care subcomponent~~ shall be limited by the lower of a ~~the~~ cost-based class ceiling, a ~~by the~~ target rate class ceiling, or an ~~by the~~ individual provider target for

each subcomponent. ~~The agency shall adjust the patient care component effective January 1, 2002.~~ The cost to adjust the direct care subcomponent shall be the net of the total funds previously allocated for the case mix add-on. ~~The agency shall make the required changes to the nursing home cost reporting forms to implement this requirement effective January 1, 2002.~~

3. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

4. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company.

5. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

6. In order to offset the cost of general and professional liability insurance, the agency shall amend the plan to allow for interim rate adjustments to reflect increases in the cost of general or professional liability insurance for nursing homes.

This provision shall be implemented to the extent existing appropriations are available.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(3) Subject to any limitations or directions provided for in the General Appropriations Act, the following Medicaid services and goods may be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be 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, with the exception of those services or goods for which the agency makes payment using a methodology based on capitation rates, average costs, or negotiated fees.

(a) Advanced registered nurse practitioner services.

(b) Birth center services.

(c) Chiropractic services.

(d) Community mental health services.

(e) Dental services, including oral and maxillofacial surgery.

(f) Durable medical equipment.

(g) Hearing services.

(h) Occupational therapy for Medicaid recipients under age 21.

(i) Optometric services.

(j) Orthodontic services.

(k) Personal care for Medicaid recipients under age 21.

(l) Physical therapy for Medicaid recipients under age 21.

(m) Physician assistant services.

(n) Podiatric services.

(o) Portable X-ray services.

(p) Private-duty nursing for Medicaid recipients under age 21.

(q) Registered nurse first assistant services.

(r) Respiratory therapy for Medicaid recipients under age 21.

(s) Speech therapy for Medicaid recipients under age 21.

(t) Visual services.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid

recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and, beginning September 1, 1995, shall include age-band differentials in such calculations.

(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.

(6) A provider of early and periodic screening, diagnosis, and treatment services to Medicaid recipients who are children under age 21 shall be reimbursed using an all-inclusive rate stipulated in a fee schedule established by the agency. A provider of the visual, dental, and hearing components of such services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(7) A provider of family planning services shall be reimbursed the lesser of the amount billed by the provider or an all-inclusive amount per type of visit for physicians and advanced registered nurse practitioners, as established by the agency in a fee schedule.

(8) A provider of home-based or community-based services rendered pursuant to a federally approved waiver shall be reimbursed based on an established or negotiated rate for each service. These rates shall be established according to an analysis of the expenditure history and prospective budget developed by each contract provider participating in the waiver

program, or under any other methodology adopted by the agency and approved by the Federal Government in accordance with the waiver. Effective July 1, 1996, privately owned and operated community-based residential facilities which meet agency requirements and which formerly received Medicaid reimbursement for the optional intermediate care facility for the mentally retarded service may participate in the developmental services waiver as part of a home-and-community-based continuum of care for Medicaid recipients who receive waiver services.

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

(10) A hospice shall be reimbursed through a prospective system for each Medicaid hospice patient at Medicaid rates using the methodology established for hospice reimbursement pursuant to Title XVIII of the federal Social Security Act.

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

(12)(a) A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(b) The agency shall adopt a fee schedule, subject to any limitations or directions provided for in the General Appropriations Act, based on a resource-based relative value scale for pricing Medicaid physician services. Under this fee schedule, physicians shall be paid a dollar amount for each service based on the average resources required to provide the service, including, but not limited to, estimates of average physician time and effort, practice expense, and the costs of professional liability insurance. The fee schedule shall provide increased reimbursement for preventive and primary care services and lowered reimbursement for specialty services by using at least two conversion factors, one for cognitive services and another for procedural services. The fee schedule shall not increase total Medicaid physician expenditures unless moneys are available, and shall be phased in over a 2-year period beginning on July 1, 1994. The Agency for Health Care Administration shall seek the advice of a 16-member advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458 and 459 and shall be composed of 50 percent primary care physicians and 50 percent specialty care physicians.

(c) Notwithstanding paragraph (b), reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which include prenatal, delivery, and postpartum care, shall be at least $1,500 per delivery for a pregnant woman

with low medical risk and at least $2,000 per delivery for a pregnant woman with high medical risk. However, reimbursement to physicians working in Regional Perinatal Intensive Care Centers designated pursuant to chapter 383, for services to certain pregnant Medicaid recipients with a high medical risk, may be made according to obstetrical care and neonatal care groupings and rates established by the agency. Nurse midwives licensed under part I of chapter 464 or midwives licensed under chapter 467 shall be reimbursed at no less than 80 percent of the low medical risk fee. The agency shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman and shall not pay more based solely on the fact that a caesarean section was performed, rather than a vaginal delivery. The agency shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed. The Department of Health shall adopt rules for appropriate insurance coverage for midwives licensed under chapter 467. Prior to the issuance and renewal of an active license, or reactivation of an inactive license for midwives licensed under chapter 467, such licensees shall submit proof of coverage with each application.

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

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

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

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

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

(d) Notwithstanding paragraphs (a)-(c):

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

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

3. 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. 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.

(a) For pharmacies with less than $75,000 in average aggregate monthly payments, the Medicaid maximum allowable fee for ingredient cost will be based on the lower of: average wholesale price (AWP) minus 15.4 percent, wholesaler acquisition cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

(b) For pharmacies with $75,000 or more in average aggregate monthly payments, the Medicaid maximum allowable fee for ingredient cost will be based on the lower of: average wholesale price (AWP) minus 17 percent, wholesaler acquisition cost (WAC) plus 3.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

(c) Medicaid providers are required to dispense generic drugs if available at lower cost and the agency has not determined that the branded product is more cost-effective, unless the prescriber has requested and received approval to require the branded product. 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 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.

(15) A provider of primary care case management services rendered pursuant to a federally approved waiver shall be reimbursed by payment of a fixed, prepaid monthly sum for each Medicaid recipient enrolled with the provider.

(16) A provider of rural health clinic services and federally qualified health center services shall be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the agency in accordance with federal regulations.

(17) A provider of targeted case management services shall be reimbursed pursuant to an established fee, except where the Federal Government requires a public provider be reimbursed on the basis of average actual costs.

(18) Unless otherwise provided for in the General Appropriations Act, a provider of transportation services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency, except when the agency has entered into a direct contract with the provider, or with a community transportation coordinator, for the provision of an all-inclusive service, or when services are provided pursuant to an agreement negotiated between the agency and the provider. The agency, as provided for in s. 427.0135, shall purchase transportation services through the community coordinated transportation system, if available, unless the agency determines a more cost-effective method for Medicaid clients. Nothing in this subsection shall be construed to limit or preclude the agency from contracting for services using a prepaid capitation rate or from establishing maximum fee schedules, individualized reimbursement policies by provider type, negotiated fees, prior authorization, competitive bidding, increased use of mass transit, or any other mechanism that the agency considers efficient and effective for the purchase of services on behalf of Medicaid clients, including implementing a transportation eligibility process. The agency shall not be required to contract with any community transportation coordinator or transportation operator that has been determined by the agency, the Department of Legal Affairs Medicaid Fraud Control Unit, or any other state or federal agency to have engaged in any abusive or fraudulent billing activities. The agency is authorized to competitively procure transportation services or make other changes necessary to secure approval of

federal waivers needed to permit federal financing of Medicaid transportation services at the service matching rate rather than the administrative matching rate.

(19) County health department services shall be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the agency in accordance with federal regulations under the authority of 42 C.F.R. s. 431.615.

(20) A renal dialysis facility that provides dialysis services under 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.

(21) The agency shall reimburse school districts which certify the state match pursuant to ss. 409.9071 and 1011.70 for the federal portion of the school district's allowable costs to deliver the services, based on the reimbursement schedule. The school district shall determine the costs for delivering services as authorized in ss. 409.9071 and 1011.70 for which the state match will be certified. Reimbursement of school-based providers is contingent on such providers being enrolled as Medicaid providers and meeting the qualifications contained in 42 C.F.R. s. 440.110, unless otherwise waived by the federal Health Care Financing Administration. Speech therapy providers who are certified through the Department of Education pursuant to rule 6A-4.0176, Florida Administrative Code, are eligible for reimbursement for services that are provided on school premises. Any employee of the school district who has been fingerprinted and has received a criminal background check in accordance with

Department of Education rules and guidelines shall be exempt from any agency requirements relating to criminal background checks.

(22) The agency shall request and implement Medicaid waivers from the federal Health Care Financing Administration 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, consistent with federal and state laws and rules.

Section 7. Paragraph (a) of subsection (39) of section 409.912, Florida Statutes, is amended, and subsection (50) is added to said 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. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. 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 mandate prior authorization, drug therapy management, or disease management participation 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. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider

network. The agency is authorized to seek federal waivers necessary to implement this policy.

(39)(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 three ~~four~~ brand-name drugs and three generic 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 three-brand ~~four-brand~~ limit or the generic drug 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 lesser of:

a. The average wholesale price (AWP) minus 15.4 percent, the wholesaler acquisition cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider for pharmacies with less than $75,000 in average aggregate monthly payments.

b. The average wholesale price (AWP) minus 17 percent, wholesaler acquisition cost (WAC) plus 3.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider for pharmacies with $75,000 or more in average aggregate monthly payments.

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. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

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 14 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 29 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" means cash rebates. Effective July 1, 2004, value-added programs as a substitution for supplemental rebates are prohibited. 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.

10. The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.

11.a. The agency shall implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency is authorized to seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Family Services, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices

based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program shall include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

c. If the agency is unable to negotiate a contract with one or more manufacturers to finance and guarantee savings associated with a behavioral drug management program by September 1, 2004, the four-brand drug limit and preferred drug list prior-authorization requirements shall apply to mental health-related drugs, notwithstanding any provision in subparagraph 1. The agency is authorized to seek federal waivers to implement this policy.

12. The agency is authorized to contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

13. The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

14. The agency may require prior authorization for the off-label use of Medicaid-covered prescribed drugs as specified in the General Appropriations Act. The agency may, but is not required to, preauthorize the use of a product for an indication not in the approved labeling. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the off-label use of a drug.

15. The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner.

(50) The agency may implement a program of all-inclusive care for children to reduce the need for hospitalization of children, as appropriate. The purpose of the program is to provide in-home hospice-like support services to children diagnosed with a life-threatening illness who are enrolled in the Children's Medical Services Network. The agency, in consultation with the Department of Health, may implement the program of all-inclusive care for children after obtaining approval from the Centers for Medicare and Medicaid Services.

Section 8. Paragraph (k) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

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

(2)

(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 percent in MediPass and 60 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 percent and 60 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 9. Subsections (6) and (7) are added to section 409.9124, Florida Statutes, to read:

409.9124 Managed care reimbursement.--

(6) The agency shall develop rates for children age 0-3 months and separate rates for children age 4-12 months. The agency shall amend the payment methodology for participating Medicaid-managed health care plans to comply with this subsection.

(7) The agency shall not pay rates at per-member per-month averages higher than that allowed for in the General Appropriations Act.

Section 10. Except as otherwise provided herein, this act shall take effect July 1, 2005.