A bill to be entitled

An act relating to health care; amending s. 393.0661, F.S.; deleting provisions authorizing the Agency for Health Care Administration to adopt emergency rules governing the home and community-based services delivery system; amending s. 400.23, F.S.; delaying provisions requiring a nursing home staffing increase; amending s. 408.034, F.S.; deleting references to the Office of Long-Term Care Policy; requiring the Agency for Health Care Administration to make recommendations to the Legislature relating to the need for nursing facility beds; amending ss. 409.903, 409.904, F.S.; deleting certain limitations on services to the medically needy; amending s. 409.906, F.S., relating to optional Medicaid services; providing for adult denture services; repealing s. 409.9065, F.S., relating to pharmaceutical expense assistance; amending s. 409.907, F.S., relating to Medicaid provider agreements; prohibiting the incorporation of a fee or rate schedule into a provider agreement; requiring that such agreements be renewed or amended only in writing; amending s. 409.908, F.S.; requiring that the agency reimburse providers according to published methodologies; authorizing adjustments in fees, rates, and other requirements under certain circumstances; removing obsolete provisions; creating s. 409.9082, F.S.; providing a Medicaid

rate-setting process; providing that the agency need not comply with ch. 120, F.S., when setting such rates; limiting judicial review of such rates; providing notice requirements or proposed and final rate methodologies; amending ss. 409.911, 409.9112, 409.9113, 409.9117, F.S., relating to the hospital disproportionate share program; revising the method for calculating the disproportionate share payment; deleting obsolete provisions; amending s. 409.91195, F.S.; revising provisions relating to the Medicaid Pharmaceutical and Therapeutics Committee and its duties with respect to developing a preferred drug list; amending s. 409.912, F.S.; authorizing the agency to contract with comprehensive behavioral health care providers in a specified service area for the purpose of demonstrating the cost-effectiveness of quality mental health services through a public hospital-operated managed care model; providing requirements for the contract; revising the Medicaid prescribed drug spending control program; eliminating case management fees; directing the Agency for Health Care Administration to implement, and authorizing it to seek federal waivers for, the program of all-inclusive care for children; authorizing the agency to adopt rules; amending s. 409.9122, F.S.; revising a provision governing assignment to a managed care option for a Medicaid recipient who does not choose a

plan or provider in certain geographic areas where the Agency for Health Care Administration contracts for comprehensive behavioral health services; amending s. 409.9124, F.S.; requiring the Agency for Health Care Administration to publish managed care reimbursement rates annually; limiting the application of certain rates and rate reductions; providing for rates applicable to children under 1 year of age; repealing s. 430.041, F.S., relating to establishing the Office of Long-Term Care Policy; amending s. 430.502, F.S.; establishing a memory disorder clinic at Florida Atlantic University; amending s. 440.02, F.S.; excluding from the term "employee" as used in ch. 440, F.S., certain Medicaid-enrolled clients served under the Family and Supported Living Medicaid Waiver program; amending s. 21, ch. 2004-270, Laws of Florida; providing criteria for clientele to be served by organizations in Lee County and Martin County under the Program of All-inclusive Care for the Elderly; providing legislative intent with respect to the applicability of provisions of the act governing contracts, fees, rates, and other methods of payment; providing for severability; providing effective dates.

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

Section 1. Section 393.0661, Florida Statutes, is amended to read:

393.0661 Home and community-based services delivery system; comprehensive redesign.--The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(1) The redesign of the home and community-based services system shall include, at a minimum, all actions necessary to achieve an appropriate rate structure, client choice within a specified service package, appropriate assessment strategies, an efficient billing process that contains reconciliation and monitoring components, a redefined role for support coordinators that avoids potential conflicts of interest, and ensures that family/client budgets are linked to levels of need.

(a) The agency shall use an assessment instrument that is reliable and valid. The agency may contract with an external vendor or may use support coordinators to complete client assessments if it develops sufficient safeguards and training to ensure ongoing inter-rater reliability.

(b) The agency, with the concurrence of the Agency for Health Care Administration, may contract for the determination of medical necessity and establishment of individual budgets.

(2) A provider of services rendered to persons with developmental disabilities pursuant to a federally approved waiver shall be reimbursed according to a rate methodology

based upon an analysis of the expenditure history and prospective costs of providers participating in the waiver program, or under any other methodology developed by the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, and approved by the Federal Government in accordance with the waiver.

~~(3) Pending the adoption of rate methodologies pursuant to nonemergency rulemaking under s. 120.54, the Agency for Health Care Administration may, at any time, adopt emergency rules under s. 120.54(4) in order to comply with subsection (4). In adopting such emergency rules, the agency need not make the findings required by s. 120.54(4)(a), and such rules shall be exempt from time limitations provided in s. 120.54(4)(c) and shall remain in effect until replaced by another emergency rule or the nonemergency adoption of the rate methodology.~~

(3)~~(4)~~ Nothing in this section or in any administrative rule shall be construed to prevent or limit the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or from limiting enrollment, or making any other adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act. If at any time, based upon an analysis by the Agency for Health Care Administration in consultation with the Agency for Persons with Disabilities, the cost of home and community-based waiver services are expected to exceed the appropriated amount, the Agency for Health Care Administration may implement any adjustment,

including provider rate reductions, within 30 days in order to remain within the appropriation.

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 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 3. Subsection (4) of section 408.034, Florida Statutes, is amended to read:

408.034 Duties and responsibilities of agency; rules.--

(4) Prior to determining that there is a need for additional community nursing facility beds in any area of the state, the agency shall determine that the need cannot be met through the provision, enhancement, or expansion of home and community-based services. In determining such need, the agency shall examine nursing home placement patterns and demographic patterns of persons entering nursing homes and the availability of and effectiveness of existing home-based and community-based service delivery systems at meeting the long-term care needs of the population. The agency shall recommend to the <u>Legislature</u> ~~Office of Long-Term Care Policy~~ changes that could be made to existing home-based and community-based delivery systems to lessen the need for additional nursing facility beds.

Section 4. 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 5. 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)(a) From July 1, 2005, through December 31, 2005, 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 services, hospice services, or home 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 6. 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 7. Effective January 1, 2006, section 409.9065, Florida Statutes, is repealed.

Section 8. Subsection (2) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.--The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(2) Each provider agreement shall be a voluntary contract between the agency and the provider~~,~~ in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program when furnishing a service or goods to a Medicaid recipient and the agency agrees to pay a sum~~,~~ determined by the agency ~~fee schedule, payment methodology, or other manner,~~ for the service or goods provided to the Medicaid recipient. The agency may require a provider to be subject to a fee or rate schedule or other payment methodology, but a fee or rate schedule or any payment methodology shall not be incorporated into the provider agreement or any other agreement relating to the provision of Medicaid goods or services. The provider agreement and other

agreement shall require that the provider agrees to accept the compensation established from time to time by the agency for Medicaid goods and services. Each provider agreement shall be effective for a stipulated period of time, shall be terminable by either party after reasonable notice, and shall be renewable by mutual agreement. Provider agreements and other agreements relating to the provision of Medicaid goods and services shall be renewed or amended only in writing. Any term of any provider agreement or other Medicaid agreement which is inconsistent with this section shall be amended by operation of law to conform to the requirements set forth in this subsection.

Section 9. 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 may 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 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 the cost-based class ceiling, ~~by~~ the target rate class ceiling, or ~~by~~ the individual

provider target. ~~The agency shall adjust the patient care component effective January 1, 2002. The cost to adjust the direct care subcomponent shall be 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, minimum data set ~~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. 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. 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 10. Section 409.9082, Florida Statutes, is created to read:

409.9082 Medicaid rate-setting process.--The agency is authorized to adopt fees, rates, or other methods of payment for Medicaid goods and services which may be amended from time to time consistent with the needs of the state Medicaid program and any limitations or directions provided for in the General Appropriations Act. The agency is not required to comply with chapter 120 when setting rates and methods of payment. The substance of Medicaid rates are not subject to judicial review, except to the extent decisions setting rates or methods of payment violate the State Constitution or federal law.

(1) For determining rates of payment for hospital services, nursing facility services, and services for intermediate care facilities for the developmentally disabled:

(a) Notice of proposed rate methodologies and justifications for the proposed rate methodologies shall be published in the Florida Administrative Weekly.

1. The notice must generally describe the proposed changes in rate methodologies and the justification for change so as to put interested persons on reasonable notice of proposed changes of rates and methodologies and their justification.

2. The notice must state how or where proposed rate methodologies and justifications can be obtained.

3. The notice must state that comments will be received, the period of time during which they will be received, and the person to whom they should be sent.

(b) Providers, beneficiaries and their representatives, and other concerned state residents shall be given a reasonable opportunity to review and comment on the proposed rate methodologies and justifications.

(c) Notice of final rate methodologies and justifications for such final rate methodologies shall be published in the Florida Administrative Weekly. The notice must generally describe the final rate methodologies and the justification for change so as to put interested persons on reasonable notice of the substance of final rate methodologies and their justification.

(d) The notice must state how or where final rate methodologies and justifications can be obtained.

(2) For determining all other rates or methods of payment:

(a) Notice shall be published in the Florida Administrative Weekly at least 48 hours before the effective date of the rate.

(b) The notice must:

1. Generally describe the proposed changes in rates or methodologies and the justification for change so as to put interested persons on reasonable notice of proposed changes of rates and methodologies and their justification;

2. Estimate any changes in annual aggregate expenditures caused or anticipated by the change;

3. State how or where the proposed changes in rates or methodologies and the justification may be obtained; and

4. State where comments may be sent.

Section 11. Paragraphs (a) and (b) of subsection (2) and paragraph (b) of subsection (4) of section 409.911, Florida Statutes, are amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

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

(a) The average of the 1998, 1999, and 2000 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2004-2005 state fiscal year and the average of the 1999, 2000, and 2001 audited disproportionate share data to determine the Medicaid days and charity care for the 2005-2006 state fiscal year.

(b) If the Agency for Health Care Administration does not have the prescribed 3 years of audited disproportionate share data as noted in paragraph (a) for a hospital, the agency shall use the average of the years of the audited disproportionate share data as noted in paragraph (a) which is available. ~~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.~~

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

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

DSHP = [(.82 x HCCD/TCCD) + (.18 x HMD/TMD)]
x 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.

1. For the 2005-2006 state fiscal year only, the DSHP for the public nonstate hospitals shall be computed using a weighted average of the disproportionate share payments for the 2004-2005 state fiscal year which uses an average of the 1998, 1999, and 2000 audited disproportionate share data and the disproportionate share payments for the 2005-2006 state fiscal year as computed using the formula above and using the average of the 1999, 2000, and 2001 audited disproportionate share data. The final DSHP for the public nonstate hospitals shall be computed as an average using the calculated payments for the 2005-2006 state fiscal year weighted at 65 percent and

the disproportionate share payments for the 2004-2005 state fiscal year weighted at 35 percent.

2. The TAAPH shall be reduced by $6,365,257 before computing the DSHP for each public hospital. The $6,365,257 shall be distributed equally between the public hospitals that are also designated statutory teaching hospitals.

Section 12. 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. For the state fiscal year 2005-2006 ~~2004-2005~~, the agency shall not distribute moneys under the regional perinatal intensive care centers disproportionate share program~~, except as noted in subsection (2)~~. ~~In the event the Centers for Medicare and Medicaid Services do not approve Florida's inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the regional perinatal intensive care centers disproportionate share program.~~

(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 x 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.

(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 13. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. 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 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. For the state fiscal year 2005-2006 ~~2004-2005~~, the agency shall not

distribute moneys under the teaching hospital disproportionate share program~~, except as noted in subsection (2)~~. ~~In the event the Centers for Medicare and Medicaid Services do not approve Florida's inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the teaching hospital disproportionate share program.~~

(1) On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals.

(b) The number of full-time equivalent trainees in the hospital, which comprises two components:

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index that comprises three components:

1. The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as

reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Administration Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to the volume of each service, expressed in terms of the standard units of measure reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all state statutory teaching hospitals.

The primary factor for the service index is computed as the sum of these three components, divided by three.

(2) By October 1 of each year, the agency shall use the following formula to calculate the maximum additional

disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

Section 14. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--For the state fiscal year 2005-2006 ~~2004-2005~~, the agency shall not distribute moneys under the primary care disproportionate share program~~, except as noted in subsection (2)~~. ~~In the event the Centers for Medicare and Medicaid Services do not approve Florida's inpatient hospital state plan amendment for the public disproportionate share program by January 1, 2005, the agency may make payments to hospitals under the 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 x 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) 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 15. Section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.--There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency ~~for Health Care Administration~~ for the purpose of developing a Medicaid preferred drug list ~~formulary pursuant to 42 U.S.C. s. 1396r-8~~.

(1) The ~~Medicaid Pharmaceutical and Therapeutics~~ committee shall be composed ~~comprised as specified in 42 U.S.C. s. 1396r-8 and consist~~ of 11 members appointed by the Governor. Four members shall be physicians, licensed under chapter 458; one member licensed under chapter 459; five members shall be pharmacists licensed under chapter 465; and one member shall be a consumer representative. The members shall be appointed to serve for terms of 2 years from the date of their appointment. Members may be appointed to more than one term. The agency ~~for Health Care Administration~~ shall serve as staff for the committee and assist them with all ministerial duties. The Governor shall ensure that at least some of the members of the ~~Medicaid Pharmaceutical and Therapeutics~~ committee represent Medicaid participating physicians and pharmacies serving all segments and diversity of the Medicaid population, and have experience in either developing or practicing under a preferred drug list ~~formulary~~. At least one of the members shall represent the interests of pharmaceutical manufacturers.

(2) Committee members shall select a chairperson and a vice chairperson each year from the committee membership.

(3) The committee shall meet at least quarterly and may meet at other times at the discretion of the chairperson

and members. The committee shall comply with rules adopted by the agency, including notice of any meeting of the committee pursuant to the requirements of the Administrative Procedure Act.

(4) Upon recommendation of the ~~Medicaid Pharmaceutical and Therapeutics~~ committee, the agency shall adopt a preferred drug list as described in s. 409.912(39). To the extent feasible, the committee shall review all drug classes included on ~~in~~ the preferred drug list ~~formulary at least~~ every 12 months, and may recommend additions to and deletions from the preferred drug list ~~formulary~~, such that the preferred drug list ~~formulary~~ provides for medically appropriate drug therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

(5) Except for ~~mental health related drugs,~~ antiretroviral drugs, ~~and drugs for nursing home residents and other institutional residents,~~ reimbursement of drugs not included on the preferred drug list ~~in the formulary~~ is subject to prior authorization.

(5)~~(6)~~ The agency ~~for Health Care Administration~~ shall publish and disseminate the preferred drug list ~~formulary~~ to all Medicaid providers in the state by Internet posting on the agency's website or in other media.

(6)~~(7)~~ The committee shall ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter, have an opportunity to present public testimony to the committee with information or evidence supporting inclusion of a product on the preferred drug list. Such public testimony shall occur prior to any recommendations made by the committee for inclusion or exclusion from the preferred drug list. Upon

timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the ~~Medicaid Pharmaceutical and Therapeutics~~ committee at the next regularly scheduled meeting following 3 months of distribution of the drug to the general public. ~~To the extent possible, upon notice by a manufacturer the agency shall also schedule a product review for any new product at the next regularly scheduled Medicaid Pharmaceutical and Therapeutics Committee.~~

~~(8) Until the Medicaid Pharmaceutical and Therapeutics Committee is appointed and a preferred drug list adopted by the agency, the agency shall use the existing voluntary preferred drug list adopted pursuant to s. 72, chapter 2000-367, Laws of Florida. Drugs not listed on the voluntary preferred drug list will require prior authorization by the agency or its contractor.~~

(7)~~(9)~~ The ~~Medicaid Pharmaceutical and Therapeutics~~ committee shall develop its preferred drug list recommendations by considering the clinical efficacy, safety, and cost-effectiveness of a product. ~~When the preferred drug formulary is adopted by the agency, if a product on the formulary is one of the first four brand name drugs used by a recipient in a month the drug shall not require prior authorization.~~

(8) Upon timely notice, the agency shall ensure that any therapeutic class of drugs which includes a drug that has been removed from distribution to the public by its manufacturer or the United States Food and Drug Administration or has been required to carry a black box warning label by the United States Food and Drug Administration because of safety

concerns is reviewed by the committee at the next regularly scheduled meeting. After such review, the committee must recommend whether to retain the therapeutic class of drugs or subcategories of drugs within a therapeutic class on the preferred drug list and whether to institute prior authorization requirements necessary to ensure patient safety.

(9)~~(10)~~ The Medicaid Pharmaceutical and Therapeutics Committee may also make recommendations to the agency regarding the prior authorization of any prescribed drug covered by Medicaid.

(10)~~(11)~~ Medicaid recipients may appeal agency preferred drug formulary decisions using the Medicaid fair hearing process administered by the Department of Children and Family Services.

Section 16. Paragraph (b) of subsection (4), paragraphs (e) and (f) of subsection (15), paragraph (a) of subsection (39), and subsections (44) and (49) of section 409.912, Florida Statutes, are amended, and subsection (50) 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. 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.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a managed care plan in an

AHCA area. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA Area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts shall be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the

cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in Area 11 who are assigned to MediPass under the provisions of s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in Area 11 for their behavioral care.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential

program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children, who are open for

child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency is authorized to seek any federal waivers to implement this initiative.

(15)

(e) By January 15 of each year, the agency shall submit a report to the Legislature ~~and the Office of Long-Term Care Policy~~ describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

3. Reasons the program is unable to place individuals in less restrictive settings when such individuals desired such services and could have been served in such settings;

4. Barriers to appropriate placement, including barriers due to policies or operations of other agencies or state-funded programs; and

5. Statutory changes necessary to ensure that individuals in need of long-term care services receive care in the least restrictive environment.

(f) The Department of Elderly Affairs shall track individuals over time who are assessed under the CARES program and who are diverted from nursing home placement. By January 15 of each year, the department shall submit to the Legislature ~~and the Office of Long-Term Care Policy~~ a longitudinal study of the individuals who are diverted from nursing home placement. The study must include:

1. The demographic characteristics of the individuals assessed and diverted from nursing home placement, including, but not limited to, age, race, gender, frailty, caregiver status, living arrangements, and geographic location;

2. A summary of community services provided to individuals for 1 year after assessment and diversion;

3. A summary of inpatient hospital admissions for individuals who have been diverted; and

4. A summary of the length of time between diversion and subsequent entry into a nursing home or death.

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

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. ~~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 the preferred drug list ~~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 unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency is authorized to seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to implement this subparagraph. 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

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

within 24 hours after receipt of a request for prior consultation; and

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

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

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: 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.

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 list as described in this subsection ~~formulary in accordance with 42 U.S.C. s. 1396r-8~~, and, pursuant to the establishment of such preferred drug list ~~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 list ~~formulary~~. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list ~~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.~~

8.~~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.

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

10.a.~~11.a.~~ The agency may ~~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 may ~~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.~~

11.~~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.

12.~~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.

13.~~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, prior-authorize ~~preauthorize~~ the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse ~~for an indication not in the approved labeling~~.

The agency ~~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. The agency may post prior-authorization criteria and protocol and updates to the list of drugs that are subject to prior authorization on an Internet website without amending its rule or engaging in additional rulemaking.

14. The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

15. The agency shall implement a step-therapy-prior authorization-approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months prior to the alternative medications that are not listed. The step-therapy-prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy-approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy-prior-authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

16.~~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.

(44) The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(h), whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31 of each year. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(49) The agency shall contract with established minority physician networks that provide services to

historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules.

(b) The agency shall reimburse each minority physician network as a fee-for-service provider, including the case management fee for primary care, if any, or as a capitated rate provider for Medicaid services. Any savings shall be shared with the minority physician networks pursuant to the contract.

(c) For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no

later than December 31. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(d) The agency may apply for any federal waivers needed to implement this subsection.

(50) The agency shall implement a program of all-inclusive care for children. The program of all-inclusive care for children shall be established to provide in-home hospice-like support services to children diagnosed with a life-threatening illness and enrolled in the Children's Medical Services network to reduce hospitalizations as appropriate. 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 17. 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 service areas 1 and 6 of the Agency for Health Care Administration ~~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 18. Section 409.9124, Florida Statutes, is amended to read:

409.9124 Managed care reimbursement.--

~~(1)~~ The agency shall develop and adopt by rule a methodology for reimbursing managed care plans.

(1)~~(2)~~ Final managed care rates shall be published annually prior to September 1 of each year, based on methodology that:

(a) Uses Medicaid's fee-for-service expenditures.

(b) Is certified as an actuarially sound computation of Medicaid fee-for-service expenditures for comparable groups of Medicaid recipients and includes all fee-for-service expenditures, including those fee-for-service expenditures attributable to recipients who are enrolled for a portion of a year in a managed care plan or waiver program.

(c) Is compliant with applicable federal laws and regulations, including, but not limited to, the requirements to include an allowance for administrative expenses and to account for all fee-for-service expenditures, including fee-for-service expenditures for those groups enrolled for part of a year.

(2)~~(3)~~ Each year prior to establishing new managed care rates, the agency shall review all prior year adjustments for changes in trend, and shall reduce or eliminate those adjustments which are not reasonable and which reflect policies or programs which are not in effect. In addition, the agency shall apply only those policy reductions applicable to the fiscal year for which the rates are being set, which can

be accurately estimated and verified by an independent actuary, and which have been implemented prior to or will be implemented during the fiscal year. The agency shall pay rates at per-member, per-month averages that equal, but do not exceed, the amounts allowed for in the General Appropriations Act applicable to the fiscal year for which the rates will be in effect.

(3)~~(4)~~ The agency shall by rule prescribe those items of financial information which each managed care plan shall report to the agency, in the time periods prescribed by rule. In prescribing items for reporting and definitions of terms, the agency shall consult with the Office of Insurance Regulation of the Financial Services Commission wherever possible.

(4)~~(5)~~ The agency shall quarterly examine the financial condition of each managed care plan, and its performance in serving Medicaid patients, and shall utilize examinations performed by the Office of Insurance Regulation wherever possible.

(5) The agency shall develop two rates for children under 1 year of age. One set of rates shall cover the month of birth through the second complete month subsequent to the month of birth, and a separate set of rates shall cover the third complete month subsequent to the month of birth through the eleventh complete month subsequent to the month of birth. The agency shall amend the payment methodology for participating Medicaid-managed health care plans to comply with this subsection.

Section 19. Section 430.041, Florida Statutes, is repealed.

Section 20. Subsection (1) of section 430.502, Florida Statutes, is amended to read:

430.502 Alzheimer's disease; memory disorder clinics and day care and respite care programs.--

(1) There is established:

(a) A memory disorder clinic at each of the three medical schools in this state;

(b) A memory disorder clinic at a major private nonprofit research-oriented teaching hospital, and may fund a memory disorder clinic at any of the other affiliated teaching hospitals;

(c) A memory disorder clinic at the Mayo Clinic in Jacksonville;

(d) A memory disorder clinic at the West Florida Regional Medical Center;

(e) The East Central Florida Memory Disorder Clinic at the Joint Center for Advanced Therapeutics and Biomedical Research of the Florida Institute of Technology and Holmes Regional Medical Center, Inc.;

(f) A memory disorder clinic at the Orlando Regional Healthcare System, Inc.;

(g) A memory disorder center located in a public hospital that is operated by an independent special hospital taxing district that governs multiple hospitals and is located in a county with a population greater than 800,000 persons;

(h) A memory disorder clinic at St. Mary's Medical Center in Palm Beach County;

(i) A memory disorder clinic at Tallahassee Memorial Healthcare;

(j) A memory disorder clinic at Lee Memorial Hospital created by chapter 63-1552, Laws of Florida, as amended;

(k) A memory disorder clinic at Sarasota Memorial Hospital in Sarasota County; ~~and~~

(l) A memory disorder clinic at Morton Plant Hospital, Clearwater, in Pinellas County; and~~,~~

(m) A memory disorder clinic at Florida Atlantic University, Boca Raton, in Palm Beach County,

for the purpose of conducting research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's disease and related memory disorders. However, memory disorder clinics funded as of June 30, 1995, shall not receive decreased funding due solely to subsequent additions of memory disorder clinics in this subsection.

Section 21. Paragraph (d) of subsection (15) of section 440.02, Florida Statutes, is amended to read:

440.02 Definitions.--When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(15)

(d) "Employee" does not include:

1. An independent contractor who is not engaged in the construction industry.

a. In order to meet the definition of independent contractor, at least four of the following criteria must be met:

(I) The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations;

(II) The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not

required to obtain a federal employer identification number under state or federal regulations;

(III) The independent contractor receives compensation for services rendered or work performed and such compensation is paid to a business rather than to an individual;

(IV) The independent contractor holds one or more bank accounts in the name of the business entity for purposes of paying business expenses or other expenses related to services rendered or work performed for compensation;

(V) The independent contractor performs work or is able to perform work for any entity in addition to or besides the employer at his or her own election without the necessity of completing an employment application or process; or

(VI) The independent contractor receives compensation for work or services rendered on a competitive-bid basis or completion of a task or a set of tasks as defined by a contractual agreement, unless such contractual agreement expressly states that an employment relationship exists.

b. If four of the criteria listed in sub-subparagraph a. do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions:

(I) The independent contractor performs or agrees to perform specific services or work for a specific amount of money and controls the means of performing the services or work.

(II) The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.

(III) The independent contractor is responsible for the satisfactory completion of the work or services that he or she performs or agrees to perform.

(IV) The independent contractor receives compensation for work or services performed for a commission or on a per-job basis and not on any other basis.

(V) The independent contractor may realize a profit or suffer a loss in connection with performing work or services.

(VI) The independent contractor has continuing or recurring business liabilities or obligations.

(VII) The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.

c. Notwithstanding anything to the contrary in this subparagraph, an individual claiming to be an independent contractor has the burden of proving that he or she is an independent contractor for purposes of this chapter.

2. A real estate licensee, if that person agrees, in writing, to perform for remuneration solely by way of commission.

3. Bands, orchestras, and musical and theatrical performers, including disk jockeys, performing in licensed premises as defined in chapter 562, if a written contract evidencing an independent contractor relationship is entered into before the commencement of such entertainment.

4. An owner-operator of a motor vehicle who transports property under a written contract with a motor carrier which evidences a relationship by which the owner-operator assumes the responsibility of an employer for the performance of the contract, if the owner-operator is required to furnish the necessary motor vehicle equipment and all costs incidental to

the performance of the contract, including, but not limited to, fuel, taxes, licenses, repairs, and hired help; and the owner-operator is paid a commission for transportation service and is not paid by the hour or on some other time-measured basis.

5. A person whose employment is both casual and not in the course of the trade, business, profession, or occupation of the employer.

6. A volunteer, except a volunteer worker for the state or a county, municipality, or other governmental entity. A person who does not receive monetary remuneration for services is presumed to be a volunteer unless there is substantial evidence that a valuable consideration was intended by both employer and employee. For purposes of this chapter, the term "volunteer" includes, but is not limited to:

a. Persons who serve in private nonprofit agencies and who receive no compensation other than expenses in an amount less than or equivalent to the standard mileage and per diem expenses provided to salaried employees in the same agency or, if such agency does not have salaried employees who receive mileage and per diem, then such volunteers who receive no compensation other than expenses in an amount less than or equivalent to the customary mileage and per diem paid to salaried workers in the community as determined by the department; and

b. Volunteers participating in federal programs established under Pub. L. No. 93-113.

7. Unless otherwise prohibited by this chapter, any officer of a corporation who elects to be exempt from this chapter. Such officer is not an employee for any reason under

this chapter until the notice of revocation of election filed pursuant to s. 440.05 is effective.

8. An officer of a corporation that is engaged in the construction industry who elects to be exempt from the provisions of this chapter, as otherwise permitted by this chapter. Such officer is not an employee for any reason until the notice of revocation of election filed pursuant to s. 440.05 is effective.

9. An exercise rider who does not work for a single horse farm or breeder, and who is compensated for riding on a case-by-case basis, provided a written contract is entered into prior to the commencement of such activity which evidences that an employee/employer relationship does not exist.

10. A taxicab, limousine, or other passenger vehicle-for-hire driver who operates said vehicles pursuant to a written agreement with a company which provides any dispatch, marketing, insurance, communications, or other services under which the driver and any fees or charges paid by the driver to the company for such services are not conditioned upon, or expressed as a proportion of, fare revenues.

11. A person who performs services as a sports official for an entity sponsoring an interscholastic sports event or for a public entity or private, nonprofit organization that sponsors an amateur sports event. For purposes of this subparagraph, such a person is an independent contractor. For purposes of this subparagraph, the term "sports official" means any person who is a neutral participant in a sports event, including, but not limited to, umpires, referees, judges, linespersons, scorekeepers, or

timekeepers. This subparagraph does not apply to any person employed by a district school board who serves as a sports official as required by the employing school board or who serves as a sports official as part of his or her responsibilities during normal school hours.

12. Medicaid-enrolled clients under chapter 393 who are excluded from the definition of employment under s. 443.1216(4)(d) and served by Adult Day Training Services under the Home and Community-Based or the Family and Supported Living Medicaid Waiver program in a sheltered workshop setting licensed by the United States Department of Labor for the purpose of training and earning less than the federal hourly minimum wage.

Section 22. Section 21 of chapter 2004-270, Laws of Florida, is amended to read:

Section 21. Notwithstanding s. 430.707, Florida Statutes, no later than September 1, 2005, or subject to federal approval of the application to be a Program of All-inclusive Care for the Elderly site, the agency shall contract with one private, not-for-profit hospice organization located in Lee County and one such organization in Martin County, such an entity shall be exempt from the requirements of chapter 641 Florida Statutes, each of which provides comprehensive services, including hospice care for frail and elderly persons. The agency shall approve ~~100 initial~~ enrollees in the Program of All-inclusive Care for the Elderly for the ~~in~~ Lee and Martin programs, subject to an appropriation by the Legislature ~~counties~~. The organization in Lee County shall serve eligible residents in Lee County and in the counties contiguous to Lee County. The organization in Martin County shall serve eligible residents in Martin County

and in the counties contiguous to Martin County. Each program may continue to enroll eligible residents when the Agency for Health Care Administration determines such residents to be eligible for nursing home confinement. Residents currently designated by the agency as eligible for nursing home confinement are automatically eligible for PACE program enrollment. ~~There shall be 50 initial enrollees in each county.~~

Section 23. Sections 8, 9, and 10 of this act are remedial in nature and it is the intent of the Legislature that the provisions of those sections apply to contracts, fees, rates, and other methods of payment in existence before, on, or after the effective date of this act.

Section 24. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 25. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2005.