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2 An act relating to health care; amending s.  
3 393.0661, F.S.; deleting provisions authorizing  
4 the Agency for Health Care Administration to  
5 adopt emergency rules governing the home and  
6 community-based services delivery system;  
7 amending s. 400.23, F.S.; delaying provisions  
8 requiring a nursing home staffing increase;  
9 amending s. 408.034, F.S.; deleting references  
10 to the Office of Long-Term Care Policy;  
11 requiring the Agency for Health Care  
12 Administration to make recommendations to the  
13 Legislature relating to the need for nursing  
14 facility beds; amending ss. 409.903, 409.904,  
15 F.S.; deleting certain limitations on services  
16 to the medically needy; amending s. 409.906,  
17 F.S., relating to optional Medicaid services;  
18 providing for adult denture services; repealing  
19 s. 409.9065, F.S., relating to pharmaceutical  
20 expense assistance; amending s. 409.907, F.S.,  
21 relating to Medicaid provider agreements;  
22 prohibiting the incorporation of a fee or rate  
23 schedule into a provider agreement; requiring  
24 that such agreements be renewed or amended only  
25 in writing; amending s. 409.908, F.S.;  
26 requiring that the agency reimburse providers  
27 according to published methodologies;  
28 authorizing adjustments in fees, rates, and  
29 other requirements under certain circumstances;  
30 removing obsolete provisions; creating s.  
31 409.9082, F.S.; providing a Medicaid

1 rate-setting process; providing that the agency  
2 need not comply with ch. 120, F.S., when  
3 setting such rates; limiting judicial review of  
4 such rates; providing notice requirements or  
5 proposed and final rate methodologies; amending  
6 ss. 409.911, 409.9112, 409.9113, 409.9117,  
7 F.S., relating to the hospital disproportionate  
8 share program; revising the method for  
9 calculating the disproportionate share payment;  
10 deleting obsolete provisions; amending s.  
11 409.91195, F.S.; revising provisions relating  
12 to the Medicaid Pharmaceutical and Therapeutics  
13 Committee and its duties with respect to  
14 developing a preferred drug list; amending s.  
15 409.912, F.S.; authorizing the agency to  
16 contract with comprehensive behavioral health  
17 care providers in a specified service area for  
18 the purpose of demonstrating the  
19 cost-effectiveness of quality mental health  
20 services through a public hospital-operated  
21 managed care model; providing requirements for  
22 the contract; revising the Medicaid prescribed  
23 drug spending control program; eliminating case  
24 management fees; directing the Agency for  
25 Health Care Administration to implement, and  
26 authorizing it to seek federal waivers for, the  
27 program of all-inclusive care for children;  
28 authorizing the agency to adopt rules; amending  
29 s. 409.9122, F.S.; revising a provision  
30 governing assignment to a managed care option  
31 for a Medicaid recipient who does not choose a

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

28  
29 Be It Enacted by the Legislature of the State of Florida:  
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1           Section 1. Section 393.0661, Florida Statutes, is  
2 amended to read:

3           393.0661 Home and community-based services delivery  
4 system; comprehensive redesign.--The Legislature finds that  
5 the home and community-based services delivery system for  
6 persons with developmental disabilities and the availability  
7 of appropriated funds are two of the critical elements in  
8 making services available. Therefore, it is the intent of the  
9 Legislature that the Agency for Persons with Disabilities  
10 shall develop and implement a comprehensive redesign of the  
11 system.

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

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

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

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

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

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

17 (3)(4) Nothing in this section or in any  
18 administrative rule shall be construed to prevent or limit the  
19 Agency for Health Care Administration, in consultation with  
20 the Agency for Persons with Disabilities, from adjusting fees,  
21 reimbursement rates, lengths of stay, number of visits, or  
22 number of services, or from limiting enrollment, or making any  
23 other adjustment necessary to comply with the availability of  
24 moneys and any limitations or directions provided for in the  
25 General Appropriations Act. If at any time, based upon an  
26 analysis by the Agency for Health Care Administration in  
27 consultation with the Agency for Persons with Disabilities,  
28 the cost of home and community-based waiver services are  
29 expected to exceed the appropriated amount, the Agency for  
30 Health Care Administration may implement any adjustment,  
31

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

3 Section 2. Paragraph (a) of subsection (3) of section  
4 400.23, Florida Statutes, is amended to read:

5 400.23 Rules; evaluation and deficiencies; licensure  
6 status.--

7 (3)(a) The agency shall adopt rules providing ~~for the~~  
8 minimum staffing requirements for nursing homes. These  
9 requirements shall include, for each nursing home facility, a  
10 minimum certified nursing assistant staffing of 2.3 hours of  
11 direct care per resident per day beginning January 1, 2002,  
12 increasing to 2.6 hours of direct care per resident per day  
13 beginning January 1, 2003, and increasing to 2.9 hours of  
14 direct care per resident per day beginning July 1, 2006 ~~2005~~.  
15 Beginning January 1, 2002, no facility shall staff below one  
16 certified nursing assistant per 20 residents, and a minimum  
17 licensed nursing staffing of 1.0 hour of direct resident care  
18 per resident per day but never below one licensed nurse per 40  
19 residents. Nursing assistants employed under s. 400.211(2) may  
20 be included in computing the staffing ratio for certified  
21 nursing assistants only if they provide nursing assistance  
22 services to residents on a full-time basis. Each nursing home  
23 must document compliance with staffing standards as required  
24 under this paragraph and post daily the names of staff on duty  
25 for the benefit of facility residents and the public. The  
26 agency shall recognize the use of licensed nurses for  
27 compliance with minimum staffing requirements for certified  
28 nursing assistants, provided that the facility otherwise meets  
29 the minimum staffing requirements for licensed nurses and that  
30 the licensed nurses ~~so recognized~~ are performing the duties of  
31 a certified nursing assistant. Unless otherwise approved by

1 the agency, licensed nurses counted toward the minimum  
2 staffing requirements for certified nursing assistants must  
3 exclusively perform the duties of a certified nursing  
4 assistant for the entire shift and ~~shall~~ not also be counted  
5 toward the minimum staffing requirements for licensed nurses.  
6 If the agency approved a facility's request to use a licensed  
7 nurse to perform both licensed nursing and certified nursing  
8 assistant duties, the facility must allocate the amount of  
9 staff time specifically spent on certified nursing assistant  
10 duties for the purpose of documenting compliance with minimum  
11 staffing requirements for certified and licensed nursing  
12 staff. In no event may the hours of a licensed nurse with dual  
13 job responsibilities be counted twice.

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

16 408.034 Duties and responsibilities of agency;  
17 rules.--

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

1           Section 4. Subsection (5) of section 409.903, Florida  
2 Statutes, is amended to read:

3           409.903 Mandatory payments for eligible persons.--The  
4 agency shall make payments for medical assistance and related  
5 services on behalf of the following persons who the  
6 department, or the Social Security Administration by contract  
7 with the Department of Children and Family Services,  
8 determines to be eligible, subject to the income, assets, and  
9 categorical eligibility tests set forth in federal and state  
10 law. Payment on behalf of these Medicaid eligible persons is  
11 subject to the availability of moneys and any limitations  
12 established by the General Appropriations Act or chapter 216.

13           (5) A pregnant woman for the duration of her pregnancy  
14 and for the postpartum period as defined in federal law and  
15 rule, or a child under age 1, if either is living in a family  
16 that has an income which is at or below 150 percent of the  
17 most current federal poverty level, or, effective January 1,  
18 1992, that has an income which is at or below 185 percent of  
19 the most current federal poverty level. Such a person is not  
20 subject to an assets test. Further, a pregnant woman who  
21 applies for eligibility for the Medicaid program through a  
22 qualified Medicaid provider must be offered the opportunity,  
23 subject to federal rules, to be made presumptively eligible  
24 for the Medicaid program. ~~Effective July 1, 2005, eligibility~~  
25 ~~for Medicaid services is eliminated for women who have incomes~~  
26 ~~above 150 percent of the most current federal poverty level.~~

27           Section 5. Subsections (1) and (2) of section 409.904,  
28 Florida Statutes, are amended to read:

29           409.904 Optional payments for eligible persons.--The  
30 agency may make payments for medical assistance and related  
31 services on behalf of the following persons who are determined



1 to be eligible subject to the income, assets, and categorical  
2 eligibility tests set forth in federal and state law. Payment  
3 on behalf of these Medicaid eligible persons is subject to the  
4 availability of moneys and any limitations established by the  
5 General Appropriations Act or chapter 216.

6 (1)(a) From July 1, 2005, through December 31, 2005, a  
7 person who is age 65 or older or is determined to be disabled,  
8 whose income is at or below 88 percent of federal poverty  
9 level, and whose assets do not exceed established limitations.

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

20 (2) A family, a pregnant woman, a child under age 21,  
21 a person age 65 or over, or a blind or disabled person, who  
22 would be eligible under any group listed in s. 409.903(1),  
23 (2), or (3), except that the income or assets of such family  
24 or person exceed established limitations. For a family or  
25 person in one of these coverage groups, medical expenses are  
26 deductible from income in accordance with federal requirements  
27 in order to make a determination of eligibility. A family or  
28 person eligible under the coverage known as the "medically  
29 needy," is eligible to receive the same services as other  
30 Medicaid recipients, with the exception of services in skilled  
31 nursing facilities and intermediate care facilities for the

1 developmentally disabled. ~~Effective July 1, 2005, the~~  
2 ~~medically needy are eligible for prescribed drug services~~  
3 ~~only.~~

4 Section 6. Paragraph (b) of subsection (1) of section  
5 409.906, Florida Statutes, is amended to read:

6 409.906 Optional Medicaid services.--Subject to  
7 specific appropriations, the agency may make payments for  
8 services which are optional to the state under Title XIX of  
9 the Social Security Act and are furnished by Medicaid  
10 providers to recipients who are determined to be eligible on  
11 the dates on which the services were provided. Any optional  
12 service that is provided shall be provided only when medically  
13 necessary and in accordance with state and federal law.

14 Optional services rendered by providers in mobile units to  
15 Medicaid recipients may be restricted or prohibited by the  
16 agency. Nothing in this section shall be construed to prevent  
17 or limit the agency from adjusting fees, reimbursement rates,  
18 lengths of stay, number of visits, or number of services, or  
19 making any other adjustments necessary to comply with the  
20 availability of moneys and any limitations or directions  
21 provided for in the General Appropriations Act or chapter 216.  
22 If necessary to safeguard the state's systems of providing  
23 services to elderly and disabled persons and subject to the  
24 notice and review provisions of s. 216.177, the Governor may  
25 direct the Agency for Health Care Administration to amend the  
26 Medicaid state plan to delete the optional Medicaid service  
27 known as "Intermediate Care Facilities for the Developmentally  
28 Disabled." Optional services may include:

29 (1) ADULT DENTAL SERVICES.--

30 (b) Beginning January 1, 2005, the agency may pay for  
31 dentures, the procedures required to seat dentures, and the

1 repair and reline of dentures, provided by or under the  
2 direction of a licensed dentist, for a recipient who is 21  
3 years of age or older. ~~This paragraph is repealed effective~~  
4 ~~July 1, 2005.~~

5 Section 7. Effective January 1, 2006, section  
6 409.9065, Florida Statutes, is repealed.

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

9 409.907 Medicaid provider agreements.--The agency may  
10 make payments for medical assistance and related services  
11 rendered to Medicaid recipients only to an individual or  
12 entity who has a provider agreement in effect with the agency,  
13 who is performing services or supplying goods in accordance  
14 with federal, state, and local law, and who agrees that no  
15 person shall, on the grounds of handicap, race, color, or  
16 national origin, or for any other reason, be subjected to  
17 discrimination under any program or activity for which the  
18 provider receives payment from the agency.

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

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

13 Section 9. Section 409.908, Florida Statutes, is  
14 amended to read:

15 409.908 Reimbursement of Medicaid providers.--Subject  
16 to specific appropriations, the agency shall reimburse  
17 Medicaid providers, in accordance with state and federal law,  
18 according to published methodologies ~~set forth in the rules of~~  
19 ~~the agency and in policy manuals and handbooks incorporated by~~  
20 ~~reference therein.~~ These methodologies may include fee  
21 schedules, reimbursement methods based on cost reporting,  
22 negotiated fees, competitive bidding pursuant to s. 287.057,  
23 and other mechanisms the agency considers efficient and  
24 effective for purchasing services or goods on behalf of  
25 recipients. If a provider is reimbursed based on cost  
26 reporting and submits a cost report late and that cost report  
27 would have been used to set a lower reimbursement rate for a  
28 rate semester, then the provider's rate for that semester  
29 shall be retroactively calculated using the new cost report,  
30 and full payment at the recalculated rate shall be effected  
31 retroactively. Medicare-granted extensions for filing cost

1 reports, if applicable, shall also apply to Medicaid cost  
2 reports. Payment for Medicaid compensable services made on  
3 behalf of Medicaid eligible persons is subject to the  
4 availability of moneys and any limitations or directions  
5 provided for in the General Appropriations Act or chapter 216.  
6 The agency may adjust ~~Further, nothing in this section shall~~  
7 ~~be construed to prevent or limit the agency from adjusting~~  
8 fees, reimbursement rates, lengths of stay, number of visits,  
9 or number of services, or make ~~making~~ any other adjustments  
10 necessary to comply with the availability of moneys and any  
11 limitations or directions provided for in the General  
12 Appropriations Act, provided the adjustment is consistent with  
13 legislative intent.

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

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

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

21 2. Recognition of the costs of graduate medical  
22 education.

23 3. Other methodologies recognized in the General  
24 Appropriations Act.

25 ~~4. Hospital inpatient rates shall be reduced by 6~~  
26 ~~percent effective July 1, 2001, and restored effective April~~  
27 ~~1, 2002.~~

28  
29 During the years funds are transferred from the Department of  
30 Health, any reimbursement supported by such funds shall be  
31 subject to certification by the Department of Health that the

1 hospital has complied with s. 381.0403. The agency is  
2 authorized to receive funds from state entities, including,  
3 but not limited to, the Department of Health, local  
4 governments, and other local political subdivisions, for the  
5 purpose of making special exception payments, including  
6 federal matching funds, through the Medicaid inpatient  
7 reimbursement methodologies. Funds received from state  
8 entities or local governments for this purpose shall be  
9 separately accounted for and shall not be commingled with  
10 other state or local funds in any manner. The agency may  
11 certify all local governmental funds used as state match under  
12 Title XIX of the Social Security Act, to the extent that the  
13 identified local health care provider that is otherwise  
14 entitled to and is contracted to receive such local funds is  
15 the benefactor under the state's Medicaid program as  
16 determined under the General Appropriations Act and pursuant  
17 to an agreement between the Agency for Health Care  
18 Administration and the local governmental entity. The local  
19 governmental entity shall use a certification form prescribed  
20 by the agency. At a minimum, the certification form shall  
21 identify the amount being certified and describe the  
22 relationship between the certifying local governmental entity  
23 and the local health care provider. The agency shall prepare  
24 an annual statement of impact which documents the specific  
25 activities undertaken during the previous fiscal year pursuant  
26 to this paragraph, to be submitted to the Legislature no later  
27 than January 1, annually.

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

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- 1           1. Such care provided to a Medicaid recipient under  
2 age 21, in which case the only limitation is medical  
3 necessity.  
4           2. Renal dialysis services.  
5           3. Other exceptions made by the agency.  
6

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

16           (c) Hospitals that provide services to a  
17 disproportionate share of low-income Medicaid recipients, or  
18 that participate in the regional perinatal intensive care  
19 center program under chapter 383, or that participate in the  
20 statutory teaching hospital disproportionate share program may  
21 receive additional reimbursement. The total amount of payment  
22 for disproportionate share hospitals shall be fixed by the  
23 General Appropriations Act. The computation of these payments  
24 must be made in compliance with all federal regulations and  
25 the methodologies described in ss. 409.911, 409.9112, and  
26 409.9113.

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

30           (2)(a)1. Reimbursement to nursing homes licensed under  
31 part II of chapter 400 and state-owned-and-operated

1 intermediate care facilities for the developmentally disabled  
2 licensed under chapter 393 must be made prospectively.

3           2. Unless otherwise limited or directed in the General  
4 Appropriations Act, reimbursement to hospitals licensed under  
5 part I of chapter 395 for the provision of swing-bed nursing  
6 home services must be made on the basis of the average  
7 statewide nursing home payment, and reimbursement to a  
8 hospital licensed under part I of chapter 395 for the  
9 provision of skilled nursing services must be made on the  
10 basis of the average nursing home payment for those services  
11 in the county in which the hospital is located. When a  
12 hospital is located in a county that does not have any  
13 community nursing homes, reimbursement must be determined by  
14 averaging the nursing home payments, in counties that surround  
15 the county in which the hospital is located. Reimbursement to  
16 hospitals, including Medicaid payment of Medicare copayments,  
17 for skilled nursing services shall be limited to 30 days,  
18 unless a prior authorization has been obtained from the  
19 agency. Medicaid reimbursement may be extended by the agency  
20 beyond 30 days, and approval must be based upon verification  
21 by the patient's physician that the patient requires  
22 short-term rehabilitative and recuperative services only, in  
23 which case an extension of no more than 15 days may be  
24 approved. Reimbursement to a hospital licensed under part I of  
25 chapter 395 for the temporary provision of skilled nursing  
26 services to nursing home residents who have been displaced as  
27 the result of a natural disaster or other emergency may not  
28 exceed the average county nursing home payment for those  
29 services in the county in which the hospital is located and is  
30 limited to the period of time which the agency considers  
31



1 necessary for continued placement of the nursing home  
2 residents in the hospital.

3 (b) Subject to any limitations or directions provided  
4 for in the General Appropriations Act, the agency shall  
5 establish and implement a Florida Title XIX Long-Term Care  
6 Reimbursement Plan (Medicaid) for nursing home care in order  
7 to provide care and services in conformance with the  
8 applicable state and federal laws, rules, regulations, and  
9 quality and safety standards and to ensure that individuals  
10 eligible for medical assistance have reasonable geographic  
11 access to such care.

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

21 2. The agency shall amend the long-term care  
22 reimbursement plan and cost reporting system to create direct  
23 care and indirect care subcomponents of the patient care  
24 component of the per diem rate. These two subcomponents  
25 together shall equal the patient care component of the per  
26 diem rate. Separate cost-based ceilings shall be calculated  
27 for each patient care subcomponent. The direct care  
28 subcomponent of the per diem rate shall be limited by the  
29 cost-based class ceiling, and the indirect care subcomponent  
30 shall be limited by the lower of the cost-based class ceiling,  
31 ~~by~~ the target rate class ceiling, or ~~by~~ the individual

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

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

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

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

24 6. In order to offset the cost of general and  
25 professional liability insurance, the agency shall amend the  
26 plan to allow for interim rate adjustments to reflect  
27 increases in the cost of general or professional liability  
28 insurance for nursing homes. This provision shall be  
29 implemented to the extent existing appropriations are  
30 available.

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

13 (3) Subject to any limitations or directions provided  
14 for in the General Appropriations Act, the following Medicaid  
15 services and goods may be reimbursed on a fee-for-service  
16 basis. For each allowable service or goods furnished in  
17 accordance with Medicaid rules, policy manuals, handbooks, and  
18 state and federal law, the payment shall be the amount billed  
19 by the provider, the provider's usual and customary charge, or  
20 the maximum allowable fee established by the agency, whichever  
21 amount is less, with the exception of those services or goods  
22 for which the agency makes payment using a methodology based  
23 on capitation rates, average costs, or negotiated fees.

- 24 (a) Advanced registered nurse practitioner services.  
25 (b) Birth center services.  
26 (c) Chiropractic services.  
27 (d) Community mental health services.  
28 (e) Dental services, including oral and maxillofacial  
29 surgery.  
30 (f) Durable medical equipment.  
31 (g) Hearing services.

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

3           (i) Optometric services.

4           (j) Orthodontic services.

5           (k) Personal care for Medicaid recipients under age  
6 21.

7           (l) Physical therapy for Medicaid recipients under age  
8 21.

9           (m) Physician assistant services.

10          (n) Podiatric services.

11          (o) Portable X-ray services.

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

14          (q) Registered nurse first assistant services.

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

17          (s) Speech therapy for Medicaid recipients under age  
18 21.

19          (t) Visual services.

20          (4) Subject to any limitations or directions provided  
21 for in the General Appropriations Act, alternative health  
22 plans, health maintenance organizations, and prepaid health  
23 plans shall be reimbursed a fixed, prepaid amount negotiated,  
24 or competitively bid pursuant to s. 287.057, by the agency and  
25 prospectively paid to the provider monthly for each Medicaid  
26 recipient enrolled. The amount may not exceed the average  
27 amount the agency determines it would have paid, based on  
28 claims experience, for recipients in the same or similar  
29 category of eligibility. The agency shall calculate capitation  
30 rates on a regional basis and, beginning September 1, 1995,  
31 shall include age-band differentials in such calculations.

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

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

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

17           (8) A provider of home-based or community-based  
18 services rendered pursuant to a federally approved waiver  
19 shall be reimbursed based on an established or negotiated rate  
20 for each service. These rates shall be established according  
21 to an analysis of the expenditure history and prospective  
22 budget developed by each contract provider participating in  
23 the waiver program, or under any other methodology adopted by  
24 the agency and approved by the Federal Government in  
25 accordance with the waiver. Effective July 1, 1996, privately  
26 owned and operated community-based residential facilities  
27 which meet agency requirements and which formerly received  
28 Medicaid reimbursement for the optional intermediate care  
29 facility for the mentally retarded service may participate in  
30 the developmental services waiver as part of a

31

1 | home-and-community-based continuum of care for Medicaid  
2 | recipients who receive waiver services.

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

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

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

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

25 |       (b) The agency shall adopt a fee schedule, subject to  
26 | any limitations or directions provided for in the General  
27 | Appropriations Act, based on a resource-based relative value  
28 | scale for pricing Medicaid physician services. Under this fee  
29 | schedule, physicians shall be paid a dollar amount for each  
30 | service based on the average resources required to provide the  
31 | service, including, but not limited to, estimates of average

1 physician time and effort, practice expense, and the costs of  
2 professional liability insurance. The fee schedule shall  
3 provide increased reimbursement for preventive and primary  
4 care services and lowered reimbursement for specialty services  
5 by using at least two conversion factors, one for cognitive  
6 services and another for procedural services. The fee  
7 schedule shall not increase total Medicaid physician  
8 expenditures unless moneys are available, and shall be phased  
9 in over a 2-year period beginning on July 1, 1994. The Agency  
10 for Health Care Administration shall seek the advice of a  
11 16-member advisory panel in formulating and adopting the fee  
12 schedule. The panel shall consist of Medicaid physicians  
13 licensed under chapters 458 and 459 and shall be composed of  
14 50 percent primary care physicians and 50 percent specialty  
15 care physicians.

16 (c) Notwithstanding paragraph (b), reimbursement fees  
17 to physicians for providing total obstetrical services to  
18 Medicaid recipients, which include prenatal, delivery, and  
19 postpartum care, shall be at least \$1,500 per delivery for a  
20 pregnant woman with low medical risk and at least \$2,000 per  
21 delivery for a pregnant woman with high medical risk. However,  
22 reimbursement to physicians working in Regional Perinatal  
23 Intensive Care Centers designated pursuant to chapter 383, for  
24 services to certain pregnant Medicaid recipients with a high  
25 medical risk, may be made according to obstetrical care and  
26 neonatal care groupings and rates established by the agency.  
27 Nurse midwives licensed under part I of chapter 464 or  
28 midwives licensed under chapter 467 shall be reimbursed at no  
29 less than 80 percent of the low medical risk fee. The agency  
30 shall by rule determine, for the purpose of this paragraph,  
31 what constitutes a high or low medical risk pregnant woman and

1 shall not pay more based solely on the fact that a caesarean  
2 section was performed, rather than a vaginal delivery. The  
3 agency shall by rule determine a prorated payment for  
4 obstetrical services in cases where only part of the total  
5 prenatal, delivery, or postpartum care was performed. The  
6 Department of Health shall adopt rules for appropriate  
7 insurance coverage for midwives licensed under chapter 467.  
8 Prior to the issuance and renewal of an active license, or  
9 reactivation of an inactive license for midwives licensed  
10 under chapter 467, such licensees shall submit proof of  
11 coverage with each application.

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

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

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

24 (c) Medicaid will pay no portion of Medicare  
25 deductibles and coinsurance when payment that Medicare has  
26 made for the service equals or exceeds what Medicaid would  
27 have paid if it had been the sole payor. The combined payment  
28 of Medicare and Medicaid shall not exceed the amount Medicaid  
29 would have paid had it been the sole payor. The Legislature  
30 finds that there has been confusion regarding the  
31 reimbursement for services rendered to dually eligible



1 Medicare beneficiaries. Accordingly, the Legislature clarifies  
2 that it has always been the intent of the Legislature before  
3 and after 1991 that, in reimbursing in accordance with fees  
4 established by Title XVIII for premiums, deductibles, and  
5 coinsurance for Medicare services rendered by physicians to  
6 Medicaid eligible persons, physicians be reimbursed at the  
7 lesser of the amount billed by the physician or the Medicaid  
8 maximum allowable fee established by the Agency for Health  
9 Care Administration, as is permitted by federal law. It has  
10 never been the intent of the Legislature with regard to such  
11 services rendered by physicians that Medicaid be required to  
12 provide any payment for deductibles, coinsurance, or  
13 copayments for Medicare cost sharing, or any expenses incurred  
14 relating thereto, in excess of the payment amount provided for  
15 under the State Medicaid plan for such service. This payment  
16 methodology is applicable even in those situations in which  
17 the payment for Medicare cost sharing for a qualified Medicare  
18 beneficiary with respect to an item or service is reduced or  
19 eliminated. This expression of the Legislature is in  
20 clarification of existing law and shall apply to payment for,  
21 and with respect to provider agreements with respect to, items  
22 or services furnished on or after the effective date of this  
23 act. This paragraph applies to payment by Medicaid for items  
24 and services furnished before the effective date of this act  
25 if such payment is the subject of a lawsuit that is based on  
26 the provisions of this section, and that is pending as of, or  
27 is initiated after, the effective date of this act.

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

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

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

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

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

11           (14) A provider of prescribed drugs shall be  
12 reimbursed the least of the amount billed by the provider, the  
13 provider's usual and customary charge, or the Medicaid maximum  
14 allowable fee established by the agency, plus a dispensing  
15 fee. The Medicaid maximum allowable fee for ingredient cost  
16 will be based on the lower of: average wholesale price (AWP)  
17 minus 15.4 percent, wholesaler acquisition cost (WAC) plus  
18 5.75 percent, the federal upper limit (FUL), the state maximum  
19 allowable cost (SMAC), or the usual and customary (UAC) charge  
20 billed by the provider. Medicaid providers are required to  
21 dispense generic drugs if available at lower cost and the  
22 agency has not determined that the branded product is more  
23 cost-effective, unless the prescriber has requested and  
24 received approval to require the branded product. The agency  
25 is directed to implement a variable dispensing fee for  
26 payments for prescribed medicines while ensuring continued  
27 access for Medicaid recipients. The variable dispensing fee  
28 may be based upon, but not limited to, either or both the  
29 volume of prescriptions dispensed by a specific pharmacy  
30 provider, the volume of prescriptions dispensed to an  
31 individual recipient, and dispensing of preferred-drug-list

1 products. The agency may increase the pharmacy dispensing fee  
2 authorized by statute and in the annual General Appropriations  
3 Act by \$0.50 for the dispensing of a Medicaid  
4 preferred-drug-list product and reduce the pharmacy dispensing  
5 fee by \$0.50 for the dispensing of a Medicaid product that is  
6 not included on the preferred drug list. The agency may  
7 establish a supplemental pharmaceutical dispensing fee to be  
8 paid to providers returning unused unit-dose packaged  
9 medications to stock and crediting the Medicaid program for  
10 the ingredient cost of those medications if the ingredient  
11 costs to be credited exceed the value of the supplemental  
12 dispensing fee. The agency is authorized to limit  
13 reimbursement for prescribed medicine in order to comply with  
14 any limitations or directions provided for in the General  
15 Appropriations Act, which may include implementing a  
16 prospective or concurrent utilization review program.

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

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

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

30 (18) Unless otherwise provided for in the General  
31 Appropriations Act, a provider of transportation services

1 shall be reimbursed the lesser of the amount billed by the  
2 provider or the Medicaid maximum allowable fee established by  
3 the agency, except when the agency has entered into a direct  
4 contract with the provider, or with a community transportation  
5 coordinator, for the provision of an all-inclusive service, or  
6 when services are provided pursuant to an agreement negotiated  
7 between the agency and the provider. The agency, as provided  
8 for in s. 427.0135, shall purchase transportation services  
9 through the community coordinated transportation system, if  
10 available, unless the agency determines a more cost-effective  
11 method for Medicaid clients. Nothing in this subsection shall  
12 be construed to limit or preclude the agency from contracting  
13 for services using a prepaid capitation rate or from  
14 establishing maximum fee schedules, individualized  
15 reimbursement policies by provider type, negotiated fees,  
16 prior authorization, competitive bidding, increased use of  
17 mass transit, or any other mechanism that the agency considers  
18 efficient and effective for the purchase of services on behalf  
19 of Medicaid clients, including implementing a transportation  
20 eligibility process. The agency shall not be required to  
21 contract with any community transportation coordinator or  
22 transportation operator that has been determined by the  
23 agency, the Department of Legal Affairs Medicaid Fraud Control  
24 Unit, or any other state or federal agency to have engaged in  
25 any abusive or fraudulent billing activities. The agency is  
26 authorized to competitively procure transportation services or  
27 make other changes necessary to secure approval of federal  
28 waivers needed to permit federal financing of Medicaid  
29 transportation services at the service matching rate rather  
30 than the administrative matching rate.  
31

1           (19) County health department services shall be  
2 reimbursed a rate per visit based on total reasonable costs of  
3 the clinic, as determined by the agency in accordance with  
4 federal regulations under the authority of 42 C.F.R. s.  
5 431.615.

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

11           (21) The agency shall reimburse school districts which  
12 certify the state match pursuant to ss. 409.9071 and 1011.70  
13 for the federal portion of the school district's allowable  
14 costs to deliver the services, based on the reimbursement  
15 schedule. The school district shall determine the costs for  
16 delivering services as authorized in ss. 409.9071 and 1011.70  
17 for which the state match will be certified. Reimbursement of  
18 school-based providers is contingent on such providers being  
19 enrolled as Medicaid providers and meeting the qualifications  
20 contained in 42 C.F.R. s. 440.110, unless otherwise waived by  
21 the federal Health Care Financing Administration. Speech  
22 therapy providers who are certified through the Department of  
23 Education pursuant to rule 6A-4.0176, Florida Administrative  
24 Code, are eligible for reimbursement for services that are  
25 provided on school premises. Any employee of the school  
26 district who has been fingerprinted and has received a  
27 criminal background check in accordance with Department of  
28 Education rules and guidelines shall be exempt from any agency  
29 requirements relating to criminal background checks.

30           (22) The agency shall request and implement Medicaid  
31 waivers from the federal Health Care Financing Administration

1 to advance and treat a portion of the Medicaid nursing home  
2 per diem as capital for creating and operating a  
3 risk-retention group for self-insurance purposes, consistent  
4 with federal and state laws and rules.

5 Section 10. Section 409.9082, Florida Statutes, is  
6 created to read:

7 409.9082 Medicaid rate-setting process.--The agency is  
8 authorized to adopt fees, rates, or other methods of payment  
9 for Medicaid goods and services which may be amended from time  
10 to time consistent with the needs of the state Medicaid  
11 program and any limitations or directions provided for in the  
12 General Appropriations Act. The agency is not required to  
13 comply with chapter 120 when setting rates and methods of  
14 payment. The substance of Medicaid rates are not subject to  
15 judicial review, except to the extent decisions setting rates  
16 or methods of payment violate the State Constitution or  
17 federal law.

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

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

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

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

31

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

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

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

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

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

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

22           (b) The notice must:

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

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

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

31           4. State where comments may be sent.

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

4 409.911 Disproportionate share program.--Subject to  
5 specific allocations established within the General  
6 Appropriations Act and any limitations established pursuant to  
7 chapter 216, the agency shall distribute, pursuant to this  
8 section, moneys to hospitals providing a disproportionate  
9 share of Medicaid or charity care services by making quarterly  
10 Medicaid payments as required. Notwithstanding the provisions  
11 of s. 409.915, counties are exempt from contributing toward  
12 the cost of this special reimbursement for hospitals serving a  
13 disproportionate share of low-income patients.

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

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

24 (b) If the Agency for Health Care Administration does  
25 not have the prescribed 3 years of audited disproportionate  
26 share data as noted in paragraph (a) for a hospital, the  
27 agency shall use the average of the years of the audited  
28 disproportionate share data as noted in paragraph (a) which is  
29 available. The average of the audited disproportionate share  
30 data for the years available if the Agency for Health Care  
31



1 ~~Administration does not have the prescribed 3 years of audited~~  
2 ~~disproportionate share data for a hospital.~~

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

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

7  
8 
$$DSHP = [(.82 \times HCCD/TCCD) + (.18 \times HMD/TMD)]$$
  
9 
$$\quad \quad \quad \times TAAPH$$
  
10 
$$TAAPH = TAA - TAAMH$$

11  
12 Where:

- 13 TAA = total available appropriation.  
14 TAAPH = total amount available for public hospitals.  
15 DSHP = disproportionate share hospital payments.  
16 HMD = hospital Medicaid days.  
17 TMD = total state Medicaid days for public hospitals.  
18 HCCD = hospital charity care dollars.  
19 TCCD = total state charity care dollars for public  
20 non-state hospitals.

21 1. For the 2005-2006 state fiscal year only, the DSHP  
22 for the public nonstate hospitals shall be computed using a  
23 weighted average of the disproportionate share payments for  
24 the 2004-2005 state fiscal year which uses an average of the  
25 1998, 1999, and 2000 audited disproportionate share data and  
26 the disproportionate share payments for the 2005-2006 state  
27 fiscal year as computed using the formula above and using the  
28 average of the 1999, 2000, and 2001 audited disproportionate  
29 share data. The final DSHP for the public nonstate hospitals  
30 shall be computed as an average using the calculated payments  
31 for the 2005-2006 state fiscal year weighted at 65 percent and

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

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

7 Section 12. Section 409.9112, Florida Statutes, is  
8 amended to read:

9 409.9112 Disproportionate share program for regional  
10 perinatal intensive care centers.--In addition to the payments  
11 made under s. 409.911, the Agency for Health Care  
12 Administration shall design and implement a system of making  
13 disproportionate share payments to those hospitals that  
14 participate in the regional perinatal intensive care center  
15 program established pursuant to chapter 383. This system of  
16 payments shall conform with federal requirements and shall  
17 distribute funds in each fiscal year for which an  
18 appropriation is made by making quarterly Medicaid payments.  
19 Notwithstanding the provisions of s. 409.915, counties are  
20 exempt from contributing toward the cost of this special  
21 reimbursement for hospitals serving a disproportionate share  
22 of low-income patients. For the state fiscal year 2005-2006  
23 ~~2004-2005~~, the agency shall not distribute moneys under the  
24 regional perinatal intensive care centers disproportionate  
25 share program, ~~except as noted in subsection (2). In the event~~  
26 ~~the Centers for Medicare and Medicaid Services do not approve~~  
27 ~~Florida's inpatient hospital state plan amendment for the~~  
28 ~~public disproportionate share program by January 1, 2005, the~~  
29 ~~agency may make payments to hospitals under the regional~~  
30 ~~perinatal intensive care centers disproportionate share~~  
31 ~~program.~~

1           (1) The following formula shall be used by the agency  
2 to calculate the total amount earned for hospitals that  
3 participate in the regional perinatal intensive care center  
4 program:

$$5 \qquad \qquad \qquad 6 \qquad \qquad \qquad \text{TAE} = \text{HDSP}/\text{THDSP}$$

7  
8 Where:

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

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

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

17  
18           (2) The total additional payment for hospitals that  
19 participate in the regional perinatal intensive care center  
20 program shall be calculated by the agency as follows:

$$21 \qquad \qquad \qquad 22 \qquad \qquad \qquad \text{TAP} = \text{TAE} \times \text{TA}$$

23  
24 Where:

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

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

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

31

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

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

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

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

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

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

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

30           (g) Agree to provide backup and referral services to  
31 the department's county health departments and other

1 low-income perinatal providers within the hospital's region,  
2 including the development of written agreements between these  
3 organizations and the hospital.

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

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

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

18 409.9113 Disproportionate share program for teaching  
19 hospitals.--In addition to the payments made under ss. 409.911  
20 and 409.9112, the Agency for Health Care Administration shall  
21 make disproportionate share payments to statutorily defined  
22 teaching hospitals for their increased costs associated with  
23 medical education programs and for tertiary health care  
24 services provided to the indigent. This system of payments  
25 shall conform with federal requirements and shall distribute  
26 funds in each fiscal year for which an appropriation is made  
27 by making quarterly Medicaid payments. Notwithstanding s.  
28 409.915, counties are exempt from contributing toward the cost  
29 of this special reimbursement for hospitals serving a  
30 disproportionate share of low-income patients. For the state  
31 fiscal year 2005-2006 ~~2004-2005~~, the agency shall not

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

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

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

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

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

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

24  
25 The primary factor for full-time equivalent trainees is  
26 computed as the sum of these two components, divided by two.

27           (c) A service index that comprises three components:

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

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

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

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

27  
28 The primary factor for the service index is computed as the  
29 sum of these three components, divided by three.

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



1 disproportionate share payment for statutorily defined  
2 teaching hospitals:

$$3$$
$$4 \qquad \qquad \qquad \text{TAP} = \text{THAF} \times \text{A}$$
$$5$$

6 Where:

7           TAP = total additional payment.  
8           THAF = teaching hospital allocation factor.  
9           A = amount appropriated for a teaching hospital  
10 disproportionate share program.

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

13           409.9117 Primary care disproportionate share  
14 program.--For the state fiscal year 2005-2006 ~~2004-2005~~, the  
15 agency shall not distribute moneys under the primary care  
16 disproportionate share program, ~~except as noted in subsection~~  
17 ~~(2). In the event the Centers for Medicare and Medicaid~~  
18 ~~Services do not approve Florida's inpatient hospital state~~  
19 ~~plan amendment for the public disproportionate share program~~  
20 ~~by January 1, 2005, the agency may make payments to hospitals~~  
21 ~~under the primary care disproportionate share program.~~

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

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

$$30$$
$$31 \qquad \qquad \qquad \text{TAE} = \text{HDSP}/\text{THDSP}$$

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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:

$$TAP = TAE \times TA$$

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

1 a prepaid capitated arrangement and who are in need of access  
2 to such physicians.

3 (c) Coordinate and provide primary care services free  
4 of charge, except copayments, to all persons with incomes up  
5 to 100 percent of the federal poverty level who are not  
6 otherwise covered by Medicaid or another program administered  
7 by a governmental entity, and to provide such services based  
8 on a sliding fee scale to all persons with incomes up to 200  
9 percent of the federal poverty level who are not otherwise  
10 covered by Medicaid or another program administered by a  
11 governmental entity, except that eligibility may be limited to  
12 persons who reside within a more limited area, as agreed to by  
13 the agency and the hospital.

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

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

31

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

5           (g) Provide inpatient services to residents within the  
6 area who are not eligible for Medicaid or Medicare, and who do  
7 not have private health insurance, regardless of ability to  
8 pay, on the basis of available space, except that nothing  
9 shall prevent the hospital from establishing bill collection  
10 programs based on ability to pay.

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

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

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

26  
27 Any hospital that fails to comply with any of the provisions  
28 of this subsection, or any other contractual condition, may  
29 not receive payments under this section until full compliance  
30 is achieved.

31

1           Section 15. Section 409.91195, Florida Statutes, is  
2 amended to read:

3           409.91195 Medicaid Pharmaceutical and Therapeutics  
4 Committee.--There is created a Medicaid Pharmaceutical and  
5 Therapeutics Committee within the agency ~~for Health Care~~  
6 ~~Administration~~ for the purpose of developing a Medicaid  
7 preferred drug list ~~formulary pursuant to 42 U.S.C. s.~~  
8 ~~1396r-8.~~

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

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

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

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

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

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

20 ~~(5)(6)~~ The agency ~~for Health Care Administration~~ shall  
21 publish and disseminate the preferred drug list formulary to  
22 all Medicaid providers in the state by Internet posting on the  
23 agency's website or in other media.

24 ~~(6)(7)~~ The committee shall ensure that interested  
25 parties, including pharmaceutical manufacturers agreeing to  
26 provide a supplemental rebate as outlined in this chapter,  
27 have an opportunity to present public testimony to the  
28 committee with information or evidence supporting inclusion of  
29 a product on the preferred drug list. Such public testimony  
30 shall occur prior to any recommendations made by the committee  
31 for inclusion or exclusion from the preferred drug list. Upon

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

11 ~~(8) Until the Medicaid Pharmaceutical and Therapeutics~~  
12 ~~Committee is appointed and a preferred drug list adopted by~~  
13 ~~the agency, the agency shall use the existing voluntary~~  
14 ~~preferred drug list adopted pursuant to s. 72, chapter~~  
15 ~~2000 367, Laws of Florida. Drugs not listed on the voluntary~~  
16 ~~preferred drug list will require prior authorization by the~~  
17 ~~agency or its contractor.~~

18 ~~(7)(9) The Medicaid Pharmaceutical and Therapeutics~~  
19 committee shall develop its preferred drug list  
20 recommendations by considering the clinical efficacy, safety,  
21 and cost-effectiveness of a product. ~~When the preferred drug~~  
22 ~~formulary is adopted by the agency, if a product on the~~  
23 ~~formulary is one of the first four brand name drugs used by a~~  
24 ~~recipient in a month the drug shall not require prior~~  
25 ~~authorization.~~

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

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

7 ~~(9)(10)~~ The Medicaid Pharmaceutical and Therapeutics  
8 Committee may also make recommendations to the agency  
9 regarding the prior authorization of any prescribed drug  
10 covered by Medicaid.

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

15 Section 16. Paragraph (b) of subsection (4),  
16 paragraphs (e) and (f) of subsection (15), paragraph (a) of  
17 subsection (39), and subsections (44) and (49) of section  
18 409.912, Florida Statutes, are amended, and subsection (50) is  
19 added to that section, to read:

20 409.912 Cost-effective purchasing of health care.--The  
21 agency shall purchase goods and services for Medicaid  
22 recipients in the most cost-effective manner consistent with  
23 the delivery of quality medical care. To ensure that medical  
24 services are effectively utilized, the agency may, in any  
25 case, require a confirmation or second physician's opinion of  
26 the correct diagnosis for purposes of authorizing future  
27 services under the Medicaid program. This section does not  
28 restrict access to emergency services or poststabilization  
29 care services as defined in 42 C.F.R. part 438.114. Such  
30 confirmation or second opinion shall be rendered in a manner  
31 approved by the agency. The agency shall maximize the use of



1 prepaid per capita and prepaid aggregate fixed-sum basis  
2 services when appropriate and other alternative service  
3 delivery and reimbursement methodologies, including  
4 competitive bidding pursuant to s. 287.057, designed to  
5 facilitate the cost-effective purchase of a case-managed  
6 continuum of care. The agency shall also require providers to  
7 minimize the exposure of recipients to the need for acute  
8 inpatient, custodial, and other institutional care and the  
9 inappropriate or unnecessary use of high-cost services. The  
10 agency may mandate prior authorization, drug therapy  
11 management, or disease management participation for certain  
12 populations of Medicaid beneficiaries, certain drug classes,  
13 or particular drugs to prevent fraud, abuse, overuse, and  
14 possible dangerous drug interactions. The Pharmaceutical and  
15 Therapeutics Committee shall make recommendations to the  
16 agency on drugs for which prior authorization is required. The  
17 agency shall inform the Pharmaceutical and Therapeutics  
18 Committee of its decisions regarding drugs subject to prior  
19 authorization. The agency is authorized to limit the entities  
20 it contracts with or enrolls as Medicaid providers by  
21 developing a provider network through provider credentialing.  
22 The agency may limit its network based on the assessment of  
23 beneficiary access to care, provider availability, provider  
24 quality standards, time and distance standards for access to  
25 care, the cultural competence of the provider network,  
26 demographic characteristics of Medicaid beneficiaries,  
27 practice and provider-to-beneficiary standards, appointment  
28 wait times, beneficiary use of services, provider turnover,  
29 provider profiling, provider licensure history, previous  
30 program integrity investigations and findings, peer review,  
31 provider Medicaid policy and billing compliance records,

1 clinical and medical record audits, and other factors.  
2 Providers shall not be entitled to enrollment in the Medicaid  
3 provider network. The agency is authorized to seek federal  
4 waivers necessary to implement this policy.

5 (4) The agency may contract with:  
6 (b) An entity that is providing comprehensive  
7 behavioral health care services to certain Medicaid recipients  
8 through a capitated, prepaid arrangement pursuant to the  
9 federal waiver provided for by s. 409.905(5). Such an entity  
10 must be licensed under chapter 624, chapter 636, or chapter  
11 641 and must possess the clinical systems and operational  
12 competence to manage risk and provide comprehensive behavioral  
13 health care to Medicaid recipients. As used in this paragraph,  
14 the term "comprehensive behavioral health care services" means  
15 covered mental health and substance abuse treatment services  
16 that are available to Medicaid recipients. The secretary of  
17 the Department of Children and Family Services shall approve  
18 provisions of procurements related to children in the  
19 department's care or custody prior to enrolling such children  
20 in a prepaid behavioral health plan. Any contract awarded  
21 under this paragraph must be competitively procured. In  
22 developing the behavioral health care prepaid plan procurement  
23 document, the agency shall ensure that the procurement  
24 document requires the contractor to develop and implement a  
25 plan to ensure compliance with s. 394.4574 related to services  
26 provided to residents of licensed assisted living facilities  
27 that hold a limited mental health license. Except as provided  
28 in subparagraph 8., the agency shall seek federal approval to  
29 contract with a single entity meeting these requirements to  
30 provide comprehensive behavioral health care services to all  
31 Medicaid recipients not enrolled in a managed care plan in an

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

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

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

1           3. Except as provided in subparagraph 8., by July 1,  
2 2006, the agency and the Department of Children and Family  
3 Services shall contract with managed care entities in each  
4 AHCA area except area 6 or arrange to provide comprehensive  
5 inpatient and outpatient mental health and substance abuse  
6 services through capitated prepaid arrangements to all  
7 Medicaid recipients who are eligible to participate in such  
8 plans under federal law and regulation. In AHCA areas where  
9 eligible individuals number less than 150,000, the agency  
10 shall contract with a single managed care plan to provide  
11 comprehensive behavioral health services to all recipients who  
12 are not enrolled in a Medicaid health maintenance  
13 organization. The agency may contract with more than one  
14 comprehensive behavioral health provider to provide care to  
15 recipients who are not enrolled in a Medicaid health  
16 maintenance organization in AHCA areas where the eligible  
17 population exceeds 150,000. Contracts for comprehensive  
18 behavioral health providers awarded pursuant to this section  
19 shall be competitively procured. Both for-profit and  
20 not-for-profit corporations shall be eligible to compete.  
21 Managed care plans contracting with the agency under  
22 subsection (3) shall provide and receive payment for the same  
23 comprehensive behavioral health benefits as provided in AHCA  
24 rules, including handbooks incorporated by reference. In AHCA  
25 Area 11, the agency shall contract with at least two  
26 comprehensive behavioral health care providers to provide  
27 behavioral health care to recipients in that area who are  
28 enrolled in, or assigned to, the MediPass program. One of the  
29 behavioral health care contracts shall be with the existing  
30 provider service network pilot project, as described in  
31 paragraph (d), for the purpose of demonstrating the

1 cost-effectiveness of the provision of quality mental health  
2 services through a public hospital-operated managed care  
3 model. Payment shall be at an agreed-upon capitated rate to  
4 ensure cost savings. Of the recipients in Area 11 who are  
5 assigned to MediPass under the provisions of s.  
6 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled  
7 recipients shall be assigned to the existing provider service  
8 network in Area 11 for their behavioral care.

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

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

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

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

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

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

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

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

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

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

13 (15)

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

18 1. Rate of diversion to community alternative  
19 programs;

20 2. CARES program staffing needs to achieve additional  
21 diversions;

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

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

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

31

1 (f) The Department of Elderly Affairs shall track  
2 individuals over time who are assessed under the CARES program  
3 and who are diverted from nursing home placement. By January  
4 15 of each year, the department shall submit to the  
5 Legislature ~~and the Office of Long Term Care Policy~~ a  
6 longitudinal study of the individuals who are diverted from  
7 nursing home placement. The study must include:

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

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

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

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

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

21 1. A Medicaid preferred drug list, which shall be a  
22 listing of cost-effective therapeutic options recommended by  
23 the Medicaid Pharmacy and Therapeutics Committee established  
24 pursuant to s. 409.91195 and adopted by the agency for each  
25 therapeutic class on the preferred drug list. At the  
26 discretion of the committee, and when feasible, the preferred  
27 drug list should include at least two products in a  
28 therapeutic class. Medicaid prescribed drug coverage for  
29 ~~brand name drugs for adult Medicaid recipients is limited to~~  
30 ~~the dispensing of four brand name drugs per month per~~  
31 ~~recipient. Children are exempt from this restriction.~~



1 Antiretroviral agents are excluded from the preferred drug  
2 list ~~this limitation. No requirements for prior authorization~~  
3 ~~or other restrictions on medications used to treat mental~~  
4 ~~illnesses such as schizophrenia, severe depression, or bipolar~~  
5 ~~disorder may be imposed on Medicaid recipients. Medications~~  
6 ~~that will be available without restriction for persons with~~  
7 ~~mental illnesses include atypical antipsychotic medications,~~  
8 ~~conventional antipsychotic medications, selective serotonin~~  
9 ~~reuptake inhibitors, and other medications used for the~~  
10 ~~treatment of serious mental illnesses.~~ The agency shall also  
11 limit the amount of a prescribed drug dispensed to no more  
12 than a 34-day supply unless the drug products' smallest  
13 marketed package is greater than a 34-day supply, or the drug  
14 is determined by the agency to be a maintenance drug in which  
15 case a 100-day maximum supply may be authorized. The agency is  
16 authorized to seek any federal waivers necessary to implement  
17 these cost-control programs and to continue participation in  
18 the federal Medicaid rebate program, or alternatively to  
19 negotiate state-only manufacturer rebates. The agency may  
20 adopt rules to implement this subparagraph. The agency shall  
21 continue to provide unlimited ~~generic drugs,~~ contraceptive  
22 drugs and items, ~~and diabetic supplies.~~ Although a drug may be  
23 ~~included on the preferred drug formulary, it would not be~~  
24 ~~exempt from the four brand limit.~~ The agency may authorize  
25 ~~exceptions to the brand name drug restriction based upon the~~  
26 ~~treatment needs of the patients, only when such exceptions are~~  
27 ~~based on prior consultation provided by the agency or an~~  
28 ~~agency contractor, but~~ The agency must establish procedures to  
29 ensure that:  
30 a. There will be a response to a request for prior  
31 consultation by telephone or other telecommunication device

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

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

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

17 2. Reimbursement to pharmacies for Medicaid prescribed  
18 drugs shall be set at the lesser of: the average wholesale  
19 price (AWP) minus 15.4 percent, the wholesaler acquisition  
20 cost (WAC) plus 5.75 percent, the federal upper limit (FUL),  
21 the state maximum allowable cost (SMAC), or the usual and  
22 customary (UAC) charge billed by the provider.

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

1 Medicaid drug benefit management program shall include  
2 initiatives to manage drug therapies for HIV/AIDS patients,  
3 patients using 20 or more unique prescriptions in a 180-day  
4 period, and the top 1,000 patients in annual spending. The  
5 agency shall enroll any Medicaid recipient in the drug benefit  
6 management program if he or she meets the specifications of  
7 this provision and is not enrolled in a Medicaid health  
8 maintenance organization.

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

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

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

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

8         7. The agency may establish a preferred drug list as  
9 described in this subsection ~~formulary in accordance with 42~~  
10 ~~U.S.C. s. 1396r-8~~, and, pursuant to the establishment of such  
11 preferred drug list formulary, it is authorized to negotiate  
12 supplemental rebates from manufacturers that are in addition  
13 to those required by Title XIX of the Social Security Act and  
14 at no less than 14 percent of the average manufacturer price  
15 as defined in 42 U.S.C. s. 1936 on the last day of a quarter  
16 unless the federal or supplemental rebate, or both, equals or  
17 exceeds 29 percent. There is no upper limit on the  
18 supplemental rebates the agency may negotiate. The agency may  
19 determine that specific products, brand-name or generic, are  
20 competitive at lower rebate percentages. Agreement to pay the  
21 minimum supplemental rebate percentage will guarantee a  
22 manufacturer that the Medicaid Pharmaceutical and Therapeutics  
23 Committee will consider a product for inclusion on the  
24 preferred drug list formulary. However, a pharmaceutical  
25 manufacturer is not guaranteed placement on the preferred drug  
26 list formulary by simply paying the minimum supplemental  
27 rebate. Agency decisions will be made on the clinical efficacy  
28 of a drug and recommendations of the Medicaid Pharmaceutical  
29 and Therapeutics Committee, as well as the price of competing  
30 products minus federal and state rebates. The agency is  
31 authorized to contract with an outside agency or contractor to

1 | conduct negotiations for supplemental rebates. For the  
2 | purposes of this section, the term "supplemental rebates"  
3 | means cash rebates. Effective July 1, 2004, value-added  
4 | programs as a substitution for supplemental rebates are  
5 | prohibited. The agency is authorized to seek any federal  
6 | waivers to implement this initiative.

7 | ~~8. The agency shall establish an advisory committee~~  
8 | ~~for the purposes of studying the feasibility of using a~~  
9 | ~~restricted drug formulary for nursing home residents and other~~  
10 | ~~institutionalized adults. The committee shall be comprised of~~  
11 | ~~seven members appointed by the Secretary of Health Care~~  
12 | ~~Administration. The committee members shall include two~~  
13 | ~~physicians licensed under chapter 458 or chapter 459; three~~  
14 | ~~pharmacists licensed under chapter 465 and appointed from a~~  
15 | ~~list of recommendations provided by the Florida Long Term Care~~  
16 | ~~Pharmacy Alliance; and two pharmacists licensed under chapter~~  
17 | ~~465.~~

18 | 8.9. The Agency for Health Care Administration shall  
19 | expand home delivery of pharmacy products. To assist Medicaid  
20 | patients in securing their prescriptions and reduce program  
21 | costs, the agency shall expand its current mail-order-pharmacy  
22 | diabetes-supply program to include all generic and brand-name  
23 | drugs used by Medicaid patients with diabetes. Medicaid  
24 | recipients in the current program may obtain nondiabetes drugs  
25 | on a voluntary basis. This initiative is limited to the  
26 | geographic area covered by the current contract. The agency  
27 | may seek and implement any federal waivers necessary to  
28 | implement this subparagraph.

29 | ~~9.10.~~ The agency shall limit to one dose per month any  
30 | drug prescribed to treat erectile dysfunction.

31 |

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

6           b. The agency, in conjunction with the Department of  
7 Children and Family Services, may implement the Medicaid  
8 behavioral drug management system that is designed to improve  
9 the quality of care and behavioral health prescribing  
10 practices based on best practice guidelines, improve patient  
11 adherence to medication plans, reduce clinical risk, and lower  
12 prescribed drug costs and the rate of inappropriate spending  
13 on Medicaid behavioral drugs. The program may ~~shall~~ include  
14 the following elements:

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

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

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

31

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

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

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

10 (VII) Disseminate electronic and published materials.

11 (VIII) Hold statewide and regional conferences.

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

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

24 11.12. The agency is authorized to contract for drug  
25 rebate administration, including, but not limited to,  
26 calculating rebate amounts, invoicing manufacturers,  
27 negotiating disputes with manufacturers, and maintaining a  
28 database of rebate collections.

29 12.13. The agency may specify the preferred daily  
30 dosing form or strength for the purpose of promoting best  
31 practices with regard to the prescribing of certain drugs as

1 specified in the General Appropriations Act and ensuring  
2 cost-effective prescribing practices.

3 ~~13.14.~~ The agency may require prior authorization for  
4 ~~the off label use of Medicaid-covered prescribed drugs as~~  
5 ~~specified in the General Appropriations Act.~~ The agency may,  
6 but is not required to, prior-authorize ~~preauthorize~~ the use  
7 of a product:

8 a. For an indication not approved in labeling;

9 b. To comply with certain clinical guidelines; or

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

13  
14 The agency ~~Prior authorization~~ may require the prescribing  
15 professional to provide information about the rationale and  
16 supporting medical evidence for the ~~off label~~ use of a drug.

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

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

31



1           15. The agency shall implement a step-therapy-prior  
2 authorization-approval process for medications excluded from  
3 the preferred drug list. Medications listed on the preferred  
4 drug list must be used within the previous 12 months prior to  
5 the alternative medications that are not listed. The  
6 step-therapy-prior authorization may require the prescriber to  
7 use the medications of a similar drug class or for a similar  
8 medical indication unless contraindicated in the Food and Drug  
9 Administration labeling. The trial period between the  
10 specified steps may vary according to the medical indication.  
11 The step-therapy-approval process shall be developed in  
12 accordance with the committee as stated in s. 409.91195(7) and  
13 (8). A drug product may be approved without meeting the  
14 step-therapy-prior-authorization criteria if the prescribing  
15 physician provides the agency with additional written medical  
16 or clinical documentation that the product is medically  
17 necessary because:  
18           a. There is not a drug on the preferred drug list to  
19 treat the disease or medical condition which is an acceptable  
20 clinical alternative;  
21           b. The alternatives have been ineffective in the  
22 treatment of the beneficiary's disease; or  
23           c. Based on historic evidence and known  
24 characteristics of the patient and the drug, the drug is  
25 likely to be ineffective, or the number of doses have been  
26 ineffective.  
27  
28 The agency shall work with the physician to determine the best  
29 alternative for the patient. The agency may adopt rules  
30 waiving the requirements for written clinical documentation  
31 for specific drugs in limited clinical situations.

1           ~~16.15-~~ The agency shall implement a return and reuse  
2 program for drugs dispensed by pharmacies to institutional  
3 recipients, which includes payment of a \$5 restocking fee for  
4 the implementation and operation of the program. The return  
5 and reuse program shall be implemented electronically and in a  
6 manner that promotes efficiency. The program must permit a  
7 pharmacy to exclude drugs from the program if it is not  
8 practical or cost-effective for the drug to be included and  
9 must provide for the return to inventory of drugs that cannot  
10 be credited or returned in a cost-effective manner.

11           (44) The Agency for Health Care Administration shall  
12 ensure that any Medicaid managed care plan as defined in s.  
13 409.9122(2)(h), whether paid on a capitated basis or a shared  
14 savings basis, is cost-effective. For purposes of this  
15 subsection, the term "cost-effective" means that a network's  
16 per-member, per-month costs to the state, including, but not  
17 limited to, fee-for-service costs, administrative costs, and  
18 case-management fees, if any, must be no greater than the  
19 state's costs associated with contracts for Medicaid services  
20 established under subsection (3), which shall be actuarially  
21 adjusted for case mix, model, and service area. The agency  
22 shall conduct actuarially sound audits adjusted for case mix  
23 and model in order to ensure such cost-effectiveness and shall  
24 publish the audit results on its Internet website and submit  
25 the audit results annually to the Governor, the President of  
26 the Senate, and the Speaker of the House of Representatives no  
27 later than December 31 of each year. Contracts established  
28 pursuant to this subsection which are not cost-effective may  
29 not be renewed.

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

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

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

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

18 |         (c) For purposes of this subsection, the term  
19 | "cost-effective" means that a network's per-member, per-month  
20 | costs to the state, including, but not limited to,  
21 | fee-for-service costs, administrative costs, and  
22 | case-management fees, if any, must be no greater than the  
23 | state's costs associated with contracts for Medicaid services  
24 | established under subsection (3), which shall be actuarially  
25 | adjusted for case mix, model, and service area. The agency  
26 | shall conduct actuarially sound audits adjusted for case mix  
27 | and model in order to ensure such cost-effectiveness and shall  
28 | publish the audit results on its Internet website and submit  
29 | the audit results annually to the Governor, the President of  
30 | the Senate, and the Speaker of the House of Representatives no  
31 |

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

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

5 (50) The agency shall implement a program of  
6 all-inclusive care for children. The program of all-inclusive  
7 care for children shall be established to provide in-home  
8 hospice-like support services to children diagnosed with a  
9 life-threatening illness and enrolled in the Children's  
10 Medical Services network to reduce hospitalizations as  
11 appropriate. The agency, in consultation with the Department  
12 of Health, may implement the program of all-inclusive care for  
13 children after obtaining approval from the Centers for  
14 Medicare and Medicaid Services.

15 Section 17. Paragraph (k) of subsection (2) of section  
16 409.9122, Florida Statutes, is amended to read:

17 409.9122 Mandatory Medicaid managed care enrollment;  
18 programs and procedures.--

19 (2)

20 (k) When a Medicaid recipient does not choose a  
21 managed care plan or MediPass provider, the agency shall  
22 assign the Medicaid recipient to a managed care plan, except  
23 in those counties in which there are fewer than two managed  
24 care plans accepting Medicaid enrollees, in which case  
25 assignment shall be to a managed care plan or a MediPass  
26 provider. Medicaid recipients in counties with fewer than two  
27 managed care plans accepting Medicaid enrollees who are  
28 subject to mandatory assignment but who fail to make a choice  
29 shall be assigned to managed care plans until an enrollment of  
30 40 percent in MediPass and 60 percent in managed care plans is  
31 achieved. Once that enrollment is achieved, the assignments

1 shall be divided in order to maintain an enrollment in  
2 MediPass and managed care plans which is in a 40 percent and  
3 60 percent proportion, respectively. In service areas 1 and 6  
4 of the Agency for Health Care Administration ~~geographic areas~~  
5 where the agency is contracting for the provision of  
6 comprehensive behavioral health services through a capitated  
7 prepaid arrangement, recipients who fail to make a choice  
8 shall be assigned equally to MediPass or a managed care plan.  
9 For purposes of this paragraph, when referring to assignment,  
10 the term "managed care plans" includes exclusive provider  
11 organizations, provider service networks, Children's Medical  
12 Services Network, minority physician networks, and pediatric  
13 emergency department diversion programs authorized by this  
14 chapter or the General Appropriations Act. When making  
15 assignments, the agency shall take into account the following  
16 criteria:

- 17 1. A managed care plan has sufficient network capacity  
18 to meet the need of members.
- 19 2. The managed care plan or MediPass has previously  
20 enrolled the recipient as a member, or one of the managed care  
21 plan's primary care providers or MediPass providers has  
22 previously provided health care to the recipient.
- 23 3. The agency has knowledge that the member has  
24 previously expressed a preference for a particular managed  
25 care plan or MediPass provider as indicated by Medicaid  
26 fee-for-service claims data, but has failed to make a choice.
- 27 4. The managed care plan's or MediPass primary care  
28 providers are geographically accessible to the recipient's  
29 residence.

30  
31

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

4           Section 18. Section 409.9124, Florida Statutes, is  
5 amended to read:

6           409.9124 Managed care reimbursement.--

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

9           ~~(1)(2)~~ Final managed care rates shall be published  
10 annually prior to September 1 of each year, based on  
11 methodology that:

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

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

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

25           ~~(2)(3)~~ Each year prior to establishing new managed  
26 care rates, the agency shall review all prior year adjustments  
27 for changes in trend, and shall reduce or eliminate those  
28 adjustments which are not reasonable and which reflect  
29 policies or programs which are not in effect. In addition, the  
30 agency shall apply only those policy reductions applicable to  
31 the fiscal year for which the rates are being set, which can

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

8       ~~(3)(4)~~ The agency shall by rule prescribe those items  
9 of financial information which each managed care plan shall  
10 report to the agency, in the time periods prescribed by rule.  
11 In prescribing items for reporting and definitions of terms,  
12 the agency shall consult with the Office of Insurance  
13 Regulation of the Financial Services Commission wherever  
14 possible.

15       ~~(4)(5)~~ The agency shall quarterly examine the  
16 financial condition of each managed care plan, and its  
17 performance in serving Medicaid patients, and shall utilize  
18 examinations performed by the Office of Insurance Regulation  
19 wherever possible.

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

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

31

1           Section 20. Subsection (1) of section 430.502, Florida  
2 Statutes, is amended to read:  
3           430.502 Alzheimer's disease; memory disorder clinics  
4 and day care and respite care programs.--  
5           (1) There is established:  
6           (a) A memory disorder clinic at each of the three  
7 medical schools in this state;  
8           (b) A memory disorder clinic at a major private  
9 nonprofit research-oriented teaching hospital, and may fund a  
10 memory disorder clinic at any of the other affiliated teaching  
11 hospitals;  
12           (c) A memory disorder clinic at the Mayo Clinic in  
13 Jacksonville;  
14           (d) A memory disorder clinic at the West Florida  
15 Regional Medical Center;  
16           (e) The East Central Florida Memory Disorder Clinic at  
17 the Joint Center for Advanced Therapeutics and Biomedical  
18 Research of the Florida Institute of Technology and Holmes  
19 Regional Medical Center, Inc. ;  
20           (f) A memory disorder clinic at the Orlando Regional  
21 Healthcare System, Inc. ;  
22           (g) A memory disorder center located in a public  
23 hospital that is operated by an independent special hospital  
24 taxing district that governs multiple hospitals and is located  
25 in a county with a population greater than 800,000 persons;  
26           (h) A memory disorder clinic at St. Mary's Medical  
27 Center in Palm Beach County;  
28           (i) A memory disorder clinic at Tallahassee Memorial  
29 Healthcare;  
30           (j) A memory disorder clinic at Lee Memorial Hospital  
31 created by chapter 63-1552, Laws of Florida, as amended;



1           (k) A memory disorder clinic at Sarasota Memorial  
2 Hospital in Sarasota County; ~~and~~  
3           (l) A memory disorder clinic at Morton Plant Hospital,  
4 Clearwater, in Pinellas County; ~~and~~  
5           (m) A memory disorder clinic at Florida Atlantic  
6 University, Boca Raton, in Palm Beach County,  
7  
8 for the purpose of conducting research and training in a  
9 diagnostic and therapeutic setting for persons suffering from  
10 Alzheimer's disease and related memory disorders. However,  
11 memory disorder clinics funded as of June 30, 1995, shall not  
12 receive decreased funding due solely to subsequent additions  
13 of memory disorder clinics in this subsection.  
14           Section 21. Paragraph (d) of subsection (15) of  
15 section 440.02, Florida Statutes, is amended to read:  
16           440.02 Definitions.--When used in this chapter, unless  
17 the context clearly requires otherwise, the following terms  
18 shall have the following meanings:  
19           (15)  
20           (d) "Employee" does not include:  
21           1. An independent contractor who is not engaged in the  
22 construction industry.  
23           a. In order to meet the definition of independent  
24 contractor, at least four of the following criteria must be  
25 met:  
26           (I) The independent contractor maintains a separate  
27 business with his or her own work facility, truck, equipment,  
28 materials, or similar accommodations;  
29           (II) The independent contractor holds or has applied  
30 for a federal employer identification number, unless the  
31 independent contractor is a sole proprietor who is not

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 6. A volunteer, except a volunteer worker for the  
10 state or a county, municipality, or other governmental entity.

11 A person who does not receive monetary remuneration for  
12 services is presumed to be a volunteer unless there is  
13 substantial evidence that a valuable consideration was  
14 intended by both employer and employee. For purposes of this  
15 chapter, the term "volunteer" includes, but is not limited to:

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

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

28 7. Unless otherwise prohibited by this chapter, any  
29 officer of a corporation who elects to be exempt from this  
30 chapter. Such officer is not an employee for any reason under  
31

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

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

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

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

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

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

6 12. Medicaid-enrolled clients under chapter 393 who  
7 are excluded from the definition of employment under s.  
8 443.1216(4)(d) and served by Adult Day Training Services under  
9 the Home and Community-Based or the Family and Supported  
10 Living Medicaid Waiver program in a sheltered workshop setting  
11 licensed by the United States Department of Labor for the  
12 purpose of training and earning less than the federal hourly  
13 minimum wage.

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

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

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

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

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

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