Amendment No.

CHAMBER ACTION

Senate	House
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The Conference Committee on HB 5085 offered the following:

Conference Committee Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (d) of subsection (2) of section 400.179, Florida Statutes, is amended to read:

400.179 Liability for Medicaid underpayments and overpayments.--

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

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

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

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid annually thereafter, in the amount of 1 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not available, projected Medicaid payments may be used. The fee shall be deposited into the Health Care Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments. The agency is authorized to transfer funds to the Grants and Donations Trust Fund for such repayments. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and

management of this account, including withdrawals from the account, subject to federal review and approval. This provision shall take effect upon becoming law and shall apply to any leasehold license application. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits.

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

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

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

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, revoke, and suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium pursuant to part

II of chapter 408, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

Section 2. Section 409.017, Florida Statutes, is amended to read:

409.017 ~~Local Funding~~ Revenue Maximization Act; legislative intent; revenue maximization program.--

(1) SHORT TITLE.--This section may be cited as the "~~Local Funding~~ Revenue Maximization Act."

(2) LEGISLATIVE INTENT.--

(a) The Legislature recognizes that state funds do not fully utilize federal funding matching opportunities for health and human services needs. It is the intent of the Legislature to authorize the use of certified local funding for federal matching programs to the fullest extent possible to maximize federal funding of local preventive services and local child development programs in this state. To that end, the Legislature expects that state agencies will take a proactive approach in implementing this legislative priority. It is the further intent of the Legislature that this act shall be revenue neutral with respect to state funds.

(b) It is the intent of the Legislature that revenue maximization opportunities using certified local funding shall

occur only after available state funds have been utilized to generate matching federal funding for the state.

(c) It is the intent of the Legislature that participation in revenue maximization is to be voluntary for local political subdivisions.

(d) Except for funds expended pursuant to Title XIX of the Social Security Act, it is the intent of the Legislature that certified local funding for federal matching programs not supplant or replace state funds. Beginning July 1, 2004, any state funds supplanted or replaced with local tax revenues for Title XIX funds shall be expressly approved in the General Appropriations Act or by the Legislative Budget Commission pursuant to chapter 216.

(e) It is the intent of the Legislature that revenue maximization shall not divert existing funds from state agencies that are currently using local funds to maximize matching federal and state funds to the greatest extent possible.

(f) It is the intent of the legislature to encourage and allow any agency to engage, through a competitive procurement process, an entity with expertise in claiming justifiable and appropriate federal funds through revenue maximization efforts both retrospectively and prospectively. This claiming may include, but not be limited to, administrative and services activities that are eligible under federal matching programs.

(3) REVENUE MAXIMIZATION PROGRAM.--

(a) For purposes of this section, the term "agency" means any state agency or department that is involved in providing health, social, or human services, including, but not limited

to, the Agency for Health Care Administration, the Agency for Workforce Innovation, the Department of Children and Family Services, the Department of Elderly Affairs, the Department of Juvenile Justice, the Department of Education, and the State Board of Education.

(b) The Agency for Health Care Administration may develop a procurement document and procedure to claim administrative federal matching funds for state provided educational services. The agency shall then competitively procure an entity with appropriate expertise and experience to retrospectively and prospectively maximize federal revenues through administrative claims for federal matching funds for state provided educational services.

(c) ~~(b)~~ Each agency shall establish programs and mechanisms designed to maximize the use of local funding for federal programs in accordance with this section.

(d) ~~(c)~~ The use of local matching funds under this section must be limited to public revenue funds of local political subdivisions, including, but not limited to, counties, municipalities, and special districts. To the extent permitted by federal law, funds donated to such local political subdivisions by private entities, such as, but not limited to, the United Way, community foundations or other foundations, and businesses, or by individuals are considered to be public revenue funds available for matching federal funding.

(e) ~~(d)~~ Subject to paragraph (g) ~~(f)~~, any federal reimbursement received as a result of the certification of local matching funds must, unless specifically prohibited by federal

law or state law, including the General Appropriations Act, and subject to the availability of specific appropriation and release authority, be returned within 30 days after receipt by the agency by the most expedient means possible to the local political subdivision providing such funding, and the local political subdivision must be provided an annual accounting of federal reimbursements received by the state or its agencies as a result of the certification of the local political subdivision's matching funds. The receipt by a local political subdivision of such matching funds must not in any way influence or be used as a factor in developing any agency's annual operating budget allocation methodology or formula or any subsequent budget amendment allocations or formulas. If necessary, agreements must be made between an agency and the local political subdivision to accomplish that purpose. Such an agreement may provide that the local political subdivision must: verify the eligibility of the local program or programs and the individuals served thereby to qualify for federal matching funds; shall develop and maintain the financial records necessary for documenting the appropriate use of federal funds; shall comply with all applicable state and federal laws, regulations, and rules that regulate such federal services; and shall reimburse the cost of any disallowance of federal funding previously provided to a local political subdivision resulting from the failure of that local political subdivision to comply with applicable state or federal laws, rules, or regulations.

(f) ~~(e)~~ Each agency, as applicable, shall work with local political subdivisions to modify any state plans and to seek and

implement any federal waivers necessary to implement this section. If such modifications or waivers require the approval of the Legislature, the agency, as applicable, shall draft such legislation and present it to the President of the Senate and the Speaker of the House of Representatives and to the respective committee chairs of the Senate and the House of Representatives by January 1, 2004, and, as applicable, annually thereafter.

(g) ~~(f)~~ Each agency, as applicable, before funds generated under this section are distributed to any local political subdivision, may deduct the actual administrative cost for implementing and monitoring the local match program; however, such administrative costs may not exceed 5 percent of the total federal reimbursement funding to be provided to the local political subdivision under paragraph (e) ~~(d)~~. To the extent that any other provision of state law applies to the certification of local matching funds for a specific program, the provisions of that statute which relate to administrative costs apply in lieu of the provisions of this paragraph. The failure to remit reimbursement to the local political subdivision will result in the payment of interest, in addition to the amount to be reimbursed at a rate pursuant to s. 55.03(1) on the unpaid amount from the expiration of the 30-day period until payment is received.

(h) ~~(g)~~ Each agency, respectively, shall annually submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, no later than January 1, a report that documents the specific activities undertaken during the

previous fiscal year under this section. The report must include, but is not limited to, a statement of the total amount of federal matching funds generated by local matching funds under this section, reported by federal funding source; the total amount of block grant funds expended during the previous fiscal year, reported by federal funding source; the total amount for federal matching fund programs, including, but not limited to, Temporary Assistance for Needy Families and Child Care and Development Fund, of unobligated funds and unliquidated funds, both as of the close of the previous federal fiscal year; the amount of unliquidated funds that is in danger of being returned to the Federal Government at the end of the current federal fiscal year; and a detailed plan and timeline for spending any unobligated and unliquidated funds by the end of the current federal fiscal year.

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

409.904 Optional payments for eligible persons.--The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) ~~(a) From July 1, 2005, through December 31, 2005, a person who is age 65 or older or is determined to be disabled,~~

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

~~(b)~~ Effective January 1, 2006, and subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage. This subsection expires June 30, 2009.

(2)(a) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled. This subsection expires June 30, 2009.

(b) Effective July 1, 2009, a pregnant woman or a child younger than 21 years of age who would be eligible under any group listed in s. 409.903, except that the income or assets of

such group exceed established limitations. For a person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A person eligible under the coverage known as the "medically needy" is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 4. Subsection (26) is added to section 409.906, Florida Statutes, to read:

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

may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(26) ANESTHESIOLOGIST ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by an anesthesiologist assistant licensed under s. 458.3475 or s. 459.023. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

Section 5. Subsections (13) and (14) of section 409.908, Florida Statutes, as amended by chapter 2007-331, Laws of Florida, are amended, and subsection (23) is added to that section, to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and

full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

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

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

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

(b)~~(c)~~ Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid

if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor. The Legislature finds that there has been confusion regarding the reimbursement for services rendered to dually eligible Medicare beneficiaries. Accordingly, the Legislature clarifies that it has always been the intent of the Legislature before and after 1991 that, in reimbursing in accordance with fees established by Title XVIII for premiums, deductibles, and coinsurance for Medicare services rendered by physicians to Medicaid eligible persons, physicians be reimbursed at the lesser of the amount billed by the physician or the Medicaid maximum allowable fee established by the Agency for Health Care Administration, as is permitted by federal law. It has never been the intent of the Legislature with regard to such services rendered by physicians that Medicaid be required to provide any payment for deductibles, coinsurance, or copayments for Medicare cost sharing, or any expenses incurred relating thereto, in excess of the payment amount provided for under the State Medicaid plan for such service. This payment methodology is applicable even in those situations in which the payment for Medicare cost sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated. This expression of the Legislature is in clarification of existing law and shall apply to payment for, and with respect to provider agreements with respect to, items or services furnished on or after the effective date of this act. This paragraph applies to payment by Medicaid for items and services furnished before the effective

date of this act if such payment is the subject of a lawsuit that is based on the provisions of this section, and that is pending as of, or is initiated after, the effective date of this act.

(c) ~~(d)~~ Notwithstanding paragraphs (a) and (b) ~~(a)-(c)~~:

1. Medicaid payments for Nursing Home Medicare part A coinsurance are ~~shall be~~ limited to the Medicaid nursing home per diem rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. The Medicaid per diem rate shall be the rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem rate adjustments.

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

3. Medicaid payments for general and specialty hospital inpatient services are ~~shall be~~ limited to the Medicare deductible and coinsurance per spell of illness. Medicaid payments for hospital Medicare Part A coinsurance shall be limited to the Medicaid hospital per diem rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. Medicaid payments for coinsurance shall be limited to the Medicaid per diem rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem adjustments. ~~Medicaid shall make no payment toward coinsurance for Medicare general hospital inpatient services.~~

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

5. Medicaid shall pay all deductibles and coinsurance for portable X-ray Medicare Part B services provided in a nursing home.

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency, plus a dispensing fee. The Medicaid maximum allowable fee for ingredient cost will be based on the lower of: average wholesale price (AWP) minus 16.4 ~~15.4~~ percent, wholesaler acquisition cost (WAC) plus 4.75 ~~5.75~~ percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider. Medicaid providers are required to dispense generic drugs if available at lower cost and the agency has not determined that the branded product is more cost-effective, unless the prescriber has requested and received approval to require the branded product. The agency is directed to implement a variable dispensing fee for payments for prescribed medicines while ensuring continued access for Medicaid recipients. The variable dispensing fee may be based upon, but not limited to, either or both the volume of prescriptions dispensed by a specific pharmacy provider, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred-drug-list products. The agency may increase the pharmacy dispensing fee authorized by statute and

in the annual General Appropriations Act by $0.50 for the dispensing of a Medicaid preferred-drug-list product and reduce the pharmacy dispensing fee by $0.50 for the dispensing of a Medicaid product that is not included on the preferred drug list. The agency may establish a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications to stock and crediting the Medicaid program for the ingredient cost of those medications if the ingredient costs to be credited exceed the value of the supplemental dispensing fee. The agency is authorized to limit reimbursement for prescribed medicine in order to comply with any limitations or directions provided for in the General Appropriations Act, which may include implementing a prospective or concurrent utilization review program.

(23)(a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for 2 fiscal years effective July 1, 2009. Reimbursement rates for the 2 fiscal years shall be as provided in the General Appropriations Act.

(b) This subsection applies to the following provider types:

1. Inpatient hospitals.

2. Outpatient hospitals.

3. Nursing homes.

4. County health departments.

5. Community intermediate care facilities for the developmentally disabled.

6. Prepaid health plans.

The agency shall apply the effect of this subsection to the reimbursement rates for nursing home diversion programs.

(c) The agency shall create a workgroup on hospital reimbursement, a workgroup on nursing facility reimbursement, and a workgroup on managed care plan payment. The workgroups shall evaluate alternative reimbursement and payment methodologies for hospitals, nursing facilities, and managed care plans, including prospective payment methodologies for hospitals and nursing facilities. The nursing facility workgroup shall also consider price-based methodologies for indirect care and acuity adjustments for direct care. The agency shall submit a report on the evaluated alternative reimbursement methodologies to the relevant committees of the Senate and the House of Representatives by November 1, 2009.

(d) This subsection expires June 30, 2011.

Section 6. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is amended to read:

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

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

(a) The average of the 2002, 2003, and 2004 ~~2000, 2001, and 2002~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2008-2009 ~~2006-2007~~ state fiscal year.

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

409.9112 Disproportionate share program for regional perinatal intensive care centers.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year 2008-2009 ~~2005-2006~~, the agency shall not distribute moneys under the regional perinatal intensive care centers disproportionate share program.

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 8. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making

quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year 2008-2009 ~~2006-2007~~, the agency shall distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospital disproportionate share program. The funds provided for statutorily defined teaching hospitals shall be distributed in the same proportion as the state fiscal year 2003-2004 teaching hospital disproportionate share funds were distributed or as otherwise provided in the General Appropriations Act. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

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

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs

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

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

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

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year

preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

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

(c) A service index that comprises three components:

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

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

index values, where the total is computed for all state statutory teaching hospitals.

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

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

(2) By October 1 of each year, the agency shall use the following formula to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

Section 9. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--For the state fiscal year 2008-2009 ~~2006-2007~~, the agency shall not distribute moneys under the primary care disproportionate share program.

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

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

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

(d) Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to

guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

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

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

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

(h) Work with the Florida Healthy Kids Corporation, the Florida Health Care Purchasing Cooperative, and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan

to persons who reside within the area and who do not have access to such a plan.

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

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

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

Section 10. Paragraph (b) of subsection (4) and paragraph (a) of subsection (39) of section 409.912, Florida Statutes, as amended by chapter 2007-331, Laws of Florida, are amended, and subsection (53) is added to that section, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to

emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions

regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211 or a Medicaid health maintenance

organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient

and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

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

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s.

409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts shall be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under the provisions of s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and

the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

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

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

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

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health

care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

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

8. All Medicaid-eligible children, except children in area 1 and children in Highlands, Hardee, Polk, or Manatee County of area 6 ~~For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children~~, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The

specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency is authorized to seek any federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).

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

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the preferred drug list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed

package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency is authorized to seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to implement this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is ~~will be~~ a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation; and

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

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: the average wholesale price (AWP) minus 16.4 ~~15.4~~ percent, the wholesaler acquisition cost (WAC) plus 4.75 ~~5.75~~ percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

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

analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

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

requirements applicable to his or her practice, as determined by the agency.

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

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

7. The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates

the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Effective July 1, 2004, value-added programs as a substitution for supplemental rebates are prohibited. The agency is authorized to seek any federal waivers to implement this initiative.

8. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered

by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

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

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

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

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

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

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

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

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

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

11.a. The agency shall implement a Medicaid prescription drug management system. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must

rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the development and adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

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

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement disease management programs in cooperation with physicians and pharmacists, along with a model quality-based medication component for individuals having chronic medical conditions.

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

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

14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may, but is not required to, prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency may post prior authorization criteria and protocol and updates to the list of drugs that are subject to prior authorization on an Internet website without amending its rule or engaging in additional rulemaking.

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

16. The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months prior to the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical

indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

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

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

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

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

17. The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a

pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused. The agency's conclusion and recommendations shall be reported to the Legislature by December 1, 2005.

(53) Before seeking an amendment to the state plan for purposes of implementing programs authorized by the Deficit Reduction Act of 2005, the agency shall notify the Legislature.

Section 11. Section 409.91206, Florida Statutes, is created to read:

409.91206 Alternatives for health and long-term care reforms.--The Governor, the President of the Senate, and the Speaker of the House of Representatives may convene workgroups to propose alternatives for cost-effective health and long-term care reforms, including, but not limited to, reforms for Medicaid.

Section 12. Paragraphs (c), (e), (f), and (i) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(c) Medicaid recipients shall have a choice of managed care plans or MediPass. The Agency for Health Care Administration, the Department of Health, the Department of Children and Family Services, and the Department of Elderly Affairs shall cooperate to ensure that each Medicaid recipient receives clear and easily understandable information that meets the following requirements:

1. Explains the concept of managed care, including MediPass.

2. Provides information on the comparative performance of managed care plans and MediPass in the areas of quality, credentialing, preventive health programs, network size and availability, and patient satisfaction.

3. Explains where additional information on each managed care plan and MediPass in the recipient's area can be obtained.

4. Explains that recipients have the right to choose their ~~own~~ managed care coverage at the time they first enroll in Medicaid and again at regular intervals set by the agency ~~plans or MediPass~~. However, if a recipient does not choose a managed care plan or MediPass, the agency will assign the recipient to a managed care plan or MediPass according to the criteria specified in this section.

5. Explains the recipient's right to complain, file a grievance, or change managed care plans or MediPass providers if the recipient is not satisfied with the managed care plan or MediPass.

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity

to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. In counties that have two or more managed care plans, a recipient already enrolled in MediPass who fails to make a choice during the annual period shall be assigned to a managed care plan if he or she is eligible for enrollment in the managed care plan. The agency shall apply for a state plan amendment or federal waiver authority, if necessary, to implement the provisions of this paragraph. All newly eligible Medicaid recipients shall have 30 days in which to make a choice of managed care plans or Medipass providers. Those Medicaid recipients who do not make a choice shall be assigned ~~to a managed care plan or MediPass~~ in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan~~, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan~~. If the SSI recipient has an ongoing relationship with a managed care plan, the agency shall assign the recipient to that managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

(f) If ~~When~~ a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who would ~~are to~~ be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g), Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be operated economically

~~operated~~. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

(i) After a recipient has made his or her ~~a~~ selection or has been enrolled in a managed care plan or MediPass, the recipient shall have 90 days to exercise the opportunity ~~in which~~ to voluntarily disenroll and select another managed care plan or MediPass ~~provider~~. After 90 days, no further changes may be made except for good cause. Good cause includes ~~shall include~~, but is not ~~be~~ limited to, poor quality of care, lack of

access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency shall develop criteria for good cause disenrollment for chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through the MediPass program. The agency must make a determination as to whether cause exists. However, the agency may require a recipient to use the managed care plan's or MediPass grievance process prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when utilized, must be completed in time to permit the recipient to disenroll by ~~no later than~~ the first day of the second month after the month the disenrollment request was made. If the managed care plan or MediPass, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

Section 13. Subsection (2) of section 409.9124, Florida Statutes, is amended to read:

409.9124 Managed care reimbursement.--The agency shall develop and adopt by rule a methodology for reimbursing managed care plans.

(2) Each year prior to establishing new managed care rates, the agency shall review all prior year adjustments for changes in trend, and shall reduce or eliminate those adjustments which are not reasonable and which reflect policies or programs which are not in effect. In addition, the agency shall apply only those policy reductions applicable to the fiscal year for which the rates are being set, which can be accurately estimated and verified by an independent actuary, and which have been implemented prior to or will be implemented during the fiscal year. ~~The agency shall pay rates at per-member, per month averages that do not exceed the amounts allowed for in the General Appropriations Act applicable to the fiscal year for which the rates will be in effect.~~

Section 14. Subsection (36) of section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's

efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments.

(36) The agency shall provide to each Medicaid recipient or his or her representative an explanation of benefits in the form of a letter that is mailed to the most recent address of

the recipient on the record with the Department of Children and Family Services. The explanation of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

Section 15. Sections 409.9061 and 430.83, Florida Statutes, are repealed.

Section 16. This act shall take effect July 1, 2008.

T I T L E A M E N D M E N T

Remove the entire title and insert:

A bill to be entitled

An act relating to health care; amending s. 400.179, F.S.; authorizing the Agency for Health Care Administration to transfer funds to the Grants and Donations Trust Fund for certain repayments; amending s. 409.017, F.S.; revising the short title; providing additional legislative intent; requiring the agency to develop a procurement document and procedure to claim certain federal matching funds;

amending s. 409.904, F.S.; discontinuing optional Medicaid payments for certain persons age 65 or over or who are blind or disabled; revising certain eligibility criteria for pregnant women and children younger than age 21; amending s. 409.906, F.S.; authorizing payment of a specified amount for Medicaid services provided by an anesthesiologist assistant; amending s. 409.908, F.S.; deleting a provision prohibiting Medicaid from making any payment toward deductibles and coinsurance for services not covered by Medicaid; providing limitations on Medicaid payments for coinsurance; providing for Medicaid to pay for certain X-ray services in a nursing home; revising reimbursement rates for providers of Medicaid prescribed drugs; requiring the agency to revise reimbursement rates for hospitals, nursing homes, county health departments, and community intermediate care facilities for the developmentally disabled for 2 fiscal years; requiring the agency to apply the effect of the revised reimbursement rates to set payment rates for managed care plans and nursing home diversion programs; requiring the agency to establish workgroups to evaluate alternative reimbursement and payment methodologies for hospitals, nursing facilities, and managed care plans; requiring a report; providing for future repeal of the suspension of the use of cost data to set certain rates; amending s. 409.911, F.S.; revising the share data used to calculate disproportionate share payments to hospitals; amending s. 409.9112, F.S.; revising the time period during which the

agency is prohibited from distributing disproportionate share payments to regional perinatal intensive care centers; amending s. 409.9113, F.S.; requiring the agency to distribute moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospital disproportionate share program for the 2008-2009 fiscal year; amending s. 409.9117, F.S.; prohibiting the agency from distributing moneys under the primary care disproportionate share program for the 2008-2009 fiscal year; amending s. 409.912, F.S.; adding a county for participation in the Medicaid behavioral health care services specialty prepaid plan; revising reimbursement rates to pharmacies for Medicaid prescribed drugs; requiring the agency to notify the Legislature before seeking an amendment to the state plan in order to implement programs authorized by the Deficit Reduction Act of 2005; creating s. 409.91206, F.S.; providing for proposed alternatives for health and long-term care reforms; amending s. 409.9122, F.S.; revising enrollment requirements relating to Medicaid managed care programs and the agency's authority to assign persons to MediPass or a managed care plan; amending s. 409.9124, F.S.; removing the limitation on the application of certain rates and rate reductions used by the agency to reimburse managed care plans; amending s. 409.913, F.S.; prohibiting mailing of the explanation of benefits for certain Medicaid services; repealing s. 409.9061, F.S., relating

to authority for a statewide laboratory services contract; repealing s. 430.83, F.S., relating to the Sunshine for Seniors Program; providing an effective date.