

20112144e2

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 400.23, F.S.;
3 revising the minimum staffing requirements for nursing
4 homes; amending s. 408.815, F.S.; requiring that the
5 Agency for Health Care Administration deny an
6 application for a license or license renewal of an
7 applicant, a controlling interest of the applicant, or
8 any entity in which a controlling interest of the
9 applicant was an owner or officer during the
10 occurrence of certain actions; authorizing the agency
11 to consider certain mitigating circumstances;
12 authorizing the agency to extend a license expiration
13 date under certain circumstances; amending s. 409.904,
14 F.S.; repealing the sunset of provisions authorizing
15 the federal waiver for certain persons age 65 and
16 older or who have a disability; repealing the sunset
17 of provisions authorizing a specified medically needy
18 program; eliminating the limit to services placed on
19 the medically needy program for pregnant women and
20 children younger than age 21; amending s. 409.905,
21 F.S.; deleting provisions requiring that the agency
22 implement hospitalist programs; amending s. 409.908,
23 F.S.; revising the factors that are excluded from the
24 direct care subcomponent of the long-term care
25 reimbursement plan for nursing home care; revising the
26 factors for calculating the maximum allowable fee for
27 pharmaceutical ingredient costs; continuing the
28 requirement that the Agency for Health Care
29 Administration set certain institutional provider

20112144e2

30 reimbursement rates in a manner that results in no
31 automatic cost-based statewide expenditure increase;
32 deleting an obsolete requirement to establish
33 workgroups to evaluate alternate reimbursement and
34 payment methods; eliminating the repeal date of the
35 suspension of the use of cost data to set certain
36 institutional provider reimbursement rates; amending
37 s. 409.9082, F.S.; revising the aggregated amount of
38 the quality assessment for nursing home facilities;
39 exempting certain nursing home facilities from the
40 quality assessment; amending s. 409.9083, F.S.;

41 eliminating the repeal date of the quality assessment
42 on privately operated intermediate care facilities for
43 the developmentally disabled; amending s. 409.911,
44 F.S.; updating references to data to be used for the
45 disproportionate share program; providing that certain
46 hospitals eligible for payments remain eligible for
47 payments during the next fiscal year; amending s.
48 409.9112, F.S.; extending the prohibition against
49 distributing moneys under the regional perinatal
50 intensive care centers disproportionate share program
51 for another year; amending s. 409.9113, F.S.;

52 extending the disproportionate share program for
53 teaching hospitals for another year; amending s.
54 409.9117, F.S.; extending the prohibition against
55 distributing moneys under the primary care
56 disproportionate share program for another year;
57 amending s. 409.912, F.S.; providing for alternatives
58 to the statewide inpatient psychiatric program;

20112144e2

59 allowing the agency to continue to contract for
60 electronic access to certain pharmacology drug
61 information; eliminating the requirement to implement
62 a wireless handheld clinical pharmacology drug
63 information database for practitioners; revising the
64 factors for calculating the maximum allowable fee for
65 pharmaceutical ingredient costs; deleting obsolete
66 provisions; authorizing the agency to seek federal
67 approval and to issue a procurement in order to
68 implement a home delivery of pharmacy products
69 program; establishing the provisions for the
70 procurement and the program; eliminating the
71 requirement for the expansion of the mail-order-
72 pharmacy diabetes-supply program; eliminating certain
73 provisions of the Medicaid prescription drug
74 management program; amending s. 409.9122, F.S.;
75 requiring the agency to assign Medicaid recipients
76 with HIV/AIDS in certain counties to a certain type of
77 managed care plan; requiring the agency to contract
78 with a single provider service network to manage the
79 MediPass program in certain counties; amending s.
80 636.0145, F.S.; exempting certain entities providing
81 services solely to Medicaid recipients under a
82 Medicaid contract from being subject to the premium
83 tax imposed on premiums, contributions, and
84 assessments received by prepaid limited health service
85 organizations; providing for prospective operation and
86 specifying that the act does not provide a basis for
87 relief from or assessment of taxes not paid, or for

20112144e2

88 determining any denial of or right to a refund of
89 taxes paid, before the effective date of the act;
90 providing legislative intent with respect to the need
91 to maintain revenues that support critical health
92 programs; repealing s. 569.23(3)(f), F.S.; abrogating
93 the repeal of provisions requiring that appellants of
94 tobacco settlement agreement judgments provide
95 specified security; authorizing the agency to contract
96 with an organization to provide certain benefits under
97 a federal program in Palm Beach County; providing an
98 exemption from ch. 641, F.S., for the organization;
99 authorizing, subject to appropriation, enrollment
100 slots for the Program of All-inclusive Care for the
101 Elderly in Palm Beach County; providing an effective
102 date.

103
104 Be It Enacted by the Legislature of the State of Florida:

105
106 Section 1. Paragraph (a) of subsection (3) of section
107 400.23, Florida Statutes, is amended to read:

108 400.23 Rules; evaluation and deficiencies; licensure
109 status.—

110 (3)(a)1. The agency shall adopt rules providing minimum
111 staffing requirements for nursing home facilities ~~homes~~. These
112 requirements must ~~shall~~ include, for each ~~nursing-home~~ facility:

113 a. A minimum weekly average of certified nursing assistant
114 and licensed nursing staffing combined of 3.6 ~~3.9~~ hours of
115 direct care per resident per day. As used in this sub-
116 subparagraph, a week is defined as Sunday through Saturday.

20112144e2

117 b. A minimum certified nursing assistant staffing of 2.5
118 ~~2.7~~ hours of direct care per resident per day. A facility may
119 not staff below one certified nursing assistant per 20
120 residents.

121 c. A minimum licensed nursing staffing of 1.0 hour of
122 direct care per resident per day. A facility may not staff below
123 one licensed nurse per 40 residents.

124 2. Nursing assistants employed under s. 400.211(2) may be
125 included in computing the staffing ratio for certified nursing
126 assistants ~~only~~ if their job responsibilities include only
127 nursing-assistant-related duties.

128 3. Each nursing home facility must document compliance with
129 staffing standards as required under this paragraph and post
130 daily the names of staff on duty for the benefit of facility
131 residents and the public.

132 4. The agency shall recognize the use of licensed nurses
133 for compliance with minimum staffing requirements for certified
134 nursing assistants ~~if, provided that~~ the nursing home facility
135 otherwise meets the minimum staffing requirements for licensed
136 nurses and ~~that~~ the licensed nurses are performing the duties of
137 a certified nursing assistant. Unless otherwise approved by the
138 agency, licensed nurses counted toward the minimum staffing
139 requirements for certified nursing assistants must exclusively
140 perform the duties of a certified nursing assistant for the
141 entire shift and not also be counted toward the minimum staffing
142 requirements for licensed nurses. If the agency approved a
143 facility's request to use a licensed nurse to perform both
144 licensed nursing and certified nursing assistant duties, the
145 facility must allocate the amount of staff time specifically

20112144e2

146 spent on certified nursing assistant duties for the purpose of
147 documenting compliance with minimum staffing requirements for
148 certified and licensed nursing staff. ~~In no event may~~ The hours
149 of a licensed nurse with dual job responsibilities may not be
150 counted twice.

151 Section 2. Section 408.815, Florida Statutes, is amended to
152 read:

153 408.815 License or application denial; revocation.—

154 (1) In addition to the grounds provided in authorizing
155 statutes, grounds that may be used by the agency for denying and
156 revoking a license or change of ownership application include
157 any of the following actions by a controlling interest:

158 (a) False representation of a material fact in the license
159 application or omission of any material fact from the
160 application.

161 (b) An intentional or negligent act materially affecting
162 the health or safety of a client of the provider.

163 (c) A violation of this part, authorizing statutes, or
164 applicable rules.

165 (d) A demonstrated pattern of deficient performance.

166 (e) The applicant, licensee, or controlling interest has
167 been or is currently excluded, suspended, or terminated from
168 participation in the state Medicaid program, the Medicaid
169 program of any other state, or the Medicare program.

170 (2) If a licensee lawfully continues to operate while a
171 denial or revocation is pending in litigation, the licensee must
172 continue to meet all other requirements of this part,
173 authorizing statutes, and applicable rules and ~~must~~ file
174 subsequent renewal applications for licensure and pay all

20112144e2

175 licensure fees. The provisions of ss. 120.60(1) and
176 408.806(3) (c) do ~~shall~~ not apply to renewal applications filed
177 during the time period in which the litigation of the denial or
178 revocation is pending until that litigation is final.

179 (3) An action under s. 408.814 or denial of the license of
180 the transferor may be grounds for denial of a change of
181 ownership application of the transferee.

182 (4) Unless an applicant is determined by the agency to
183 satisfy the provisions of subsection (5) for the action in
184 question, the agency shall deny an application for a license or
185 license renewal based upon any of the following actions of an
186 applicant, a controlling interest of the applicant, or any
187 entity in which a controlling interest of the applicant was an
188 owner or officer when the following actions occurred ~~In addition~~
189 ~~to the grounds provided in authorizing statutes, the agency~~
190 ~~shall deny an application for a license or license renewal if~~
191 ~~the applicant or a person having a controlling interest in an~~
192 ~~applicant has been:~~

193 (a) A conviction or ~~Convicted of, or enters~~ a plea of
194 guilty or nolo contendere to, regardless of adjudication, a
195 felony under chapter 409, chapter 817, chapter 893, 21 U.S.C.
196 ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud,
197 Medicare fraud, or insurance fraud, unless the sentence and any
198 subsequent period of probation for such convictions or plea
199 ended more than 15 years before ~~prior to~~ the date of the
200 application; or

201 (b) Termination ~~Terminated~~ for cause from the Medicare
202 Florida Medicaid program or a state Medicaid program ~~pursuant to~~
203 ~~s. 409.913,~~ unless the applicant has been in good standing with

20112144e2

204 the Medicare program or a state ~~the Florida~~ Medicaid program for
205 the most recent 5 years and the termination occurred at least 20
206 years before the date of the application. ~~;~~ ~~or~~

207 ~~(c) Terminated for cause, pursuant to the appeals~~
208 ~~procedures established by the state or Federal Government, from~~
209 ~~the federal Medicare program or from any other state Medicaid~~
210 ~~program, unless the applicant has been in good standing with a~~
211 ~~state Medicaid program or the federal Medicare program for the~~
212 ~~most recent 5 years and the termination occurred at least 20~~
213 ~~years prior to the date of the application.~~

214 (5) For any application subject to denial under subsection
215 (4), the agency may consider mitigating circumstances as
216 applicable, including, but not limited to:

217 (a) Completion or lawful release from confinement,
218 supervision, or sanction, including the terms of probation, and
219 full restitution;

220 (b) Execution of a compliance plan with the agency;

221 (c) Compliance with an integrity agreement or compliance
222 plan with another government agency;

223 (d) Determination by any state Medicaid program or the
224 Medicare program that the controlling interest or entity in
225 which the controlling interest was an owner or officer is
226 currently allowed to participate in the state Medicaid program
227 or the Medicare program, directly as a provider or indirectly as
228 an owner or officer of a provider entity;

229 (e) Continuation of licensure by the controlling interest
230 or entity in which the controlling interest was an owner or
231 officer, directly as a licensee or indirectly as an owner or
232 officer of a licensed entity in the state where the action

20112144e2

233 occurred;

234 (f) Overall impact upon the public health, safety, or
235 welfare; or

236 (g) Determination that a license denial is not commensurate
237 with the prior action taken by the Medicare or state Medicaid
238 program.

239

240 After considering the circumstances set forth in this
241 subsection, the agency shall grant the license, with or without
242 conditions, grant a provisional license for a period of no more
243 than the licensure cycle, with or without conditions, or deny
244 the license.

245 (6) In order to ensure the health, safety, and welfare of
246 clients when a license has been denied, revoked, or is set to
247 terminate, the agency may extend the license expiration date for
248 up to 30 days for the sole purpose of allowing the safe and
249 orderly discharge of clients. The agency may impose conditions
250 on the extension, including, but not limited to, prohibiting or
251 limiting admissions, expedited discharge planning, required
252 status reports, and mandatory monitoring by the agency or third
253 parties. When imposing these conditions, the agency shall
254 consider the nature and number of clients, the availability and
255 location of acceptable alternative placements, and the ability
256 of the licensee to continue providing care to the clients. The
257 agency may terminate the extension or modify the conditions at
258 any time. This authority is in addition to any other authority
259 granted to the agency under chapter 120, this part, and
260 authorizing statutes but creates no right or entitlement to an
261 extension of a license expiration date.

20112144e2

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

264 409.904 Optional payments for eligible persons.—The agency
265 may make payments for medical assistance and related services on
266 behalf of the following persons who are determined to be
267 eligible subject to the income, assets, and categorical
268 eligibility tests set forth in federal and state law. Payment on
269 behalf of these Medicaid eligible persons is subject to the
270 availability of moneys and any limitations established by the
271 General Appropriations Act or chapter 216.

272 (1) ~~Effective January 1, 2006, and~~ Subject to federal
273 waiver approval, a person who is age 65 or older or is
274 determined to be disabled, whose income is at or below 88
275 percent of the federal poverty level, whose assets do not exceed
276 established limitations, and who is not eligible for Medicare
277 or, if eligible for Medicare, is also eligible for and receiving
278 Medicaid-covered institutional care services, hospice services,
279 or home and community-based services. The agency shall seek
280 federal authorization through a waiver to provide this coverage.
281 ~~This subsection expires June 30, 2011.~~

282 (2)(a) A family, a pregnant woman, a child under age 21, a
283 person age 65 or over, or a blind or disabled person, who would
284 be eligible under any group listed in s. 409.903(1), (2), or
285 (3), except that the income or assets of such family or person
286 exceed established limitations. For a family or person in one of
287 these coverage groups, medical expenses are deductible from
288 income in accordance with federal requirements in order to make
289 a determination of eligibility. A family or person eligible
290 under the coverage known as the "medically needy," is eligible

20112144e2

291 to receive the same services as other Medicaid recipients, with
292 the exception of services in skilled nursing facilities and
293 intermediate care facilities for the developmentally disabled.
294 ~~This paragraph expires June 30, 2011.~~

295 ~~(b) Effective July 1, 2011, a pregnant woman or a child~~
296 ~~younger than 21 years of age who would be eligible under any~~
297 ~~group listed in s. 409.903, except that the income or assets of~~
298 ~~such group exceed established limitations. For a person in one~~
299 ~~of these coverage groups, medical expenses are deductible from~~
300 ~~income in accordance with federal requirements in order to make~~
301 ~~a determination of eligibility. A person eligible under the~~
302 ~~coverage known as the "medically needy" is eligible to receive~~
303 ~~the same services as other Medicaid recipients, with the~~
304 ~~exception of services in skilled nursing facilities and~~
305 ~~intermediate care facilities for the developmentally disabled.~~

306 Section 4. Paragraphs (d), (e), and (f) of subsection (5)
307 of section 409.905, Florida Statutes, are amended to read:

308 409.905 Mandatory Medicaid services.—The agency may make
309 payments for the following services, which are required of the
310 state by Title XIX of the Social Security Act, furnished by
311 Medicaid providers to recipients who are determined to be
312 eligible on the dates on which the services were provided. Any
313 service under this section shall be provided only when medically
314 necessary and in accordance with state and federal law.
315 Mandatory services rendered by providers in mobile units to
316 Medicaid recipients may be restricted by the agency. Nothing in
317 this section shall be construed to prevent or limit the agency
318 from adjusting fees, reimbursement rates, lengths of stay,
319 number of visits, number of services, or any other adjustments

20112144e2

320 necessary to comply with the availability of moneys and any
321 limitations or directions provided for in the General
322 Appropriations Act or chapter 216.

323 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
324 all covered services provided for the medical care and treatment
325 of a recipient who is admitted as an inpatient by a licensed
326 physician or dentist to a hospital licensed under part I of
327 chapter 395. However, the agency shall limit the payment for
328 inpatient hospital services for a Medicaid recipient 21 years of
329 age or older to 45 days or the number of days necessary to
330 comply with the General Appropriations Act.

331 ~~(d) The agency shall implement a hospitalist program in~~
332 ~~nonteaching hospitals, select counties, or statewide. The~~
333 ~~program shall require hospitalists to manage Medicaid~~
334 ~~recipients' hospital admissions and lengths of stay. Individuals~~
335 ~~who are dually eligible for Medicare and Medicaid are exempted~~
336 ~~from this requirement. Medicaid participating physicians and~~
337 ~~other practitioners with hospital admitting privileges shall~~
338 ~~coordinate and review admissions of Medicaid recipients with the~~
339 ~~hospitalist. The agency may competitively bid a contract for~~
340 ~~selection of a single qualified organization to provide~~
341 ~~hospitalist services. The agency may procure hospitalist~~
342 ~~services by individual county or may combine counties in a~~
343 ~~single procurement. The qualified organization shall contract~~
344 ~~with or employ board-eligible physicians in Miami-Dade, Palm~~
345 ~~Beach, Hillsborough, Pasco, and Pinellas Counties. The agency is~~
346 ~~authorized to seek federal waivers to implement this program.~~

347 (d) ~~(e)~~ The agency shall implement a comprehensive
348 utilization management program for hospital neonatal intensive

20112144e2

349 care stays in certain high-volume participating hospitals,
350 select counties, or statewide, and ~~shall~~ replace existing
351 hospital inpatient utilization management programs for neonatal
352 intensive care admissions. The program shall be designed to
353 manage the lengths of stay for children being treated in
354 neonatal intensive care units and must seek the earliest
355 medically appropriate discharge to the child's home or other
356 less costly treatment setting. The agency may competitively bid
357 a contract for the selection of a qualified organization to
358 provide neonatal intensive care utilization management services.
359 The agency may ~~is authorized to~~ seek ~~any~~ federal waivers to
360 implement this initiative.

361 (e) ~~(f)~~ The agency may develop and implement a program to
362 reduce the number of hospital readmissions among the non-
363 Medicare population eligible in areas 9, 10, and 11.

364 Section 5. Paragraph (b) of subsection (2) and subsections
365 (14) and (23) of section 409.908, Florida Statutes, are amended
366 to read:

367 409.908 Reimbursement of Medicaid providers.—Subject to
368 specific appropriations, the agency shall reimburse Medicaid
369 providers, in accordance with state and federal law, according
370 to methodologies set forth in the rules of the agency and in
371 policy manuals and handbooks incorporated by reference therein.
372 These methodologies may include fee schedules, reimbursement
373 methods based on cost reporting, negotiated fees, competitive
374 bidding pursuant to s. 287.057, and other mechanisms the agency
375 considers efficient and effective for purchasing services or
376 goods on behalf of recipients. If a provider is reimbursed based
377 on cost reporting and submits a cost report late and that cost

20112144e2

378 report would have been used to set a lower reimbursement rate
379 for a rate semester, then the provider's rate for that semester
380 shall be retroactively calculated using the new cost report, and
381 full payment at the recalculated rate shall be effected
382 retroactively. Medicare-granted extensions for filing cost
383 reports, if applicable, shall also apply to Medicaid cost
384 reports. Payment for Medicaid compensable services made on
385 behalf of Medicaid eligible persons is subject to the
386 availability of moneys and any limitations or directions
387 provided for in the General Appropriations Act or chapter 216.
388 Further, nothing in this section shall be construed to prevent
389 or limit the agency from adjusting fees, reimbursement rates,
390 lengths of stay, number of visits, or number of services, or
391 making any other adjustments necessary to comply with the
392 availability of moneys and any limitations or directions
393 provided for in the General Appropriations Act, provided the
394 adjustment is consistent with legislative intent.

395 (2)

396 (b) Subject to any limitations or directions ~~provided for~~
397 in the General Appropriations Act, the agency shall establish
398 and implement a state Florida Title XIX Long-Term Care
399 Reimbursement Plan ~~(Medicaid)~~ for nursing home care in order to
400 provide care and services in conformance with the applicable
401 state and federal laws, rules, regulations, and quality and
402 safety standards and to ensure that individuals eligible for
403 medical assistance have reasonable geographic access to such
404 care.

405 1. The agency shall amend the long-term care reimbursement
406 plan and cost reporting system to create direct care and

20112144e2

407 indirect care subcomponents of the patient care component of the
408 per diem rate. These two subcomponents together shall equal the
409 patient care component of the per diem rate. Separate cost-based
410 ceilings shall be calculated for each patient care subcomponent.
411 The direct care subcomponent of the per diem rate shall be
412 limited by the cost-based class ceiling, and the indirect care
413 subcomponent may be limited by the lower of the cost-based class
414 ceiling, the target rate class ceiling, or the individual
415 provider target.

416 2. The direct care subcomponent shall include salaries and
417 benefits of direct care staff providing nursing services
418 including registered nurses, licensed practical nurses, and
419 certified nursing assistants who deliver care directly to
420 residents in the nursing home facility. This excludes nursing
421 administration, ~~minimum data set, and care plan coordinators,~~
422 staff development, and staffing coordinator, and the
423 administrative portion of the minimum data set and care plan
424 coordinators.

425 3. All other patient care costs shall be included in the
426 indirect care cost subcomponent of the patient care per diem
427 rate. ~~There shall be no~~ Costs may not be allocated directly or
428 indirectly ~~allocated~~ to the direct care subcomponent from a home
429 office or management company.

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

435 5. In order to offset the cost of general and professional

20112144e2

436 liability insurance, the agency shall amend the plan to allow
437 for interim rate adjustments to reflect increases in the cost of
438 general or professional liability insurance for nursing homes.
439 This provision shall be implemented to the extent existing
440 appropriations are available.

441
442 It is the intent of the Legislature that the reimbursement plan
443 achieve the goal of providing access to health care for nursing
444 home residents who require large amounts of care while
445 encouraging diversion services as an alternative to nursing home
446 care for residents who can be served within the community. The
447 agency shall base the establishment of any maximum rate of
448 payment, whether overall or component, on the available moneys
449 as provided for in the General Appropriations Act. The agency
450 may base the maximum rate of payment on the results of
451 scientifically valid analysis and conclusions derived from
452 objective statistical data pertinent to the particular maximum
453 rate of payment.

454 (14) A provider of prescribed drugs shall be reimbursed the
455 least of the amount billed by the provider, the provider's usual
456 and customary charge, or the Medicaid maximum allowable fee
457 established by the agency, plus a dispensing fee. The Medicaid
458 maximum allowable fee for ingredient cost must ~~will~~ be based on
459 the lowest ~~lower~~ of: the average wholesale price (AWP) minus
460 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5
461 ~~4.75~~ percent, the federal upper limit (FUL), the state maximum
462 allowable cost (SMAC), or the usual and customary (UAC) charge
463 billed by the provider.

464 (a) Medicaid providers must ~~are required to~~ dispense

20112144e2

465 generic drugs if available at lower cost and the agency has not
466 determined that the branded product is more cost-effective,
467 unless the prescriber has requested and received approval to
468 require the branded product.

469 (b) The agency shall ~~is directed to~~ implement a variable
470 dispensing fee for ~~payments for~~ prescribed medicines while
471 ensuring continued access for Medicaid recipients. The variable
472 dispensing fee may be based upon, but not limited to, either or
473 both the volume of prescriptions dispensed by a specific
474 pharmacy provider, the volume of prescriptions dispensed to an
475 individual recipient, and dispensing of preferred-drug-list
476 products.

477 (c) The agency may increase the pharmacy dispensing fee
478 authorized by statute and in the ~~annual~~ General Appropriations
479 Act by \$0.50 for the dispensing of a Medicaid preferred-drug-
480 list product and reduce the pharmacy dispensing fee by \$0.50 for
481 the dispensing of a Medicaid product that is not included on the
482 preferred drug list.

483 (d) The agency may establish a supplemental pharmaceutical
484 dispensing fee to be paid to providers returning unused unit-
485 dose packaged medications to stock and crediting the Medicaid
486 program for the ingredient cost of those medications if the
487 ingredient costs to be credited exceed the value of the
488 supplemental dispensing fee.

489 (e) The agency may ~~is authorized to~~ limit reimbursement for
490 prescribed medicine in order to comply with any limitations or
491 directions provided ~~for~~ in the General Appropriations Act, which
492 may include implementing a prospective or concurrent utilization
493 review program.

20112144e2

494 (23) (a) The agency shall establish rates at a level that
495 ensures no increase in statewide expenditures resulting from a
496 change in unit costs ~~for 2 fiscal years~~ effective July 1, 2011
497 ~~2009~~. Reimbursement rates ~~for the 2 fiscal years~~ shall be as
498 provided in the General Appropriations Act.

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

- 501 1. Inpatient hospitals.
- 502 2. Outpatient hospitals.
- 503 3. Nursing homes.
- 504 4. County health departments.
- 505 5. Community intermediate care facilities for the
506 developmentally disabled.
- 507 6. Prepaid health plans.

508 (c) The agency shall apply the effect of this subsection to
509 the reimbursement rates for nursing home diversion programs.

510 ~~(e) The agency shall create a workgroup on hospital
511 reimbursement, a workgroup on nursing facility reimbursement,
512 and a workgroup on managed care plan payment. The workgroups
513 shall evaluate alternative reimbursement and payment
514 methodologies for hospitals, nursing facilities, and managed
515 care plans, including prospective payment methodologies for
516 hospitals and nursing facilities. The nursing facility workgroup
517 shall also consider price-based methodologies for indirect care
518 and acuity adjustments for direct care. The agency shall submit
519 a report on the evaluated alternative reimbursement
520 methodologies to the relevant committees of the Senate and the
521 House of Representatives by November 1, 2009.~~

522 ~~(d) This subsection expires June 30, 2011.~~

20112144e2

523 Section 6. Subsection (2) and paragraph (d) of subsection
524 (3) of section 409.9082, Florida Statutes, are amended to read:
525 409.9082 Quality assessment on nursing home facility
526 providers; exemptions; purpose; federal approval required;
527 remedies.—

528 (2) Effective April 1, 2009, a quality assessment ~~there is~~
529 imposed upon each nursing home facility ~~a quality assessment~~.
530 The aggregated amount of assessments for all nursing home
531 facilities in a given year shall be an amount not exceeding the
532 maximum percentage allowed under federal law ~~5.5 percent~~ of the
533 total aggregate net patient service revenue of assessed
534 facilities. The agency shall calculate the quality assessment
535 rate annually on a per-resident-day basis, exclusive of those
536 resident days funded by the Medicare program, as reported by the
537 facilities. The per-resident-day assessment rate must ~~shall~~ be
538 uniform except as prescribed in subsection (3). Each facility
539 shall report monthly to the agency its total number of resident
540 days, exclusive of Medicare Part A resident days, and ~~shall~~
541 remit an amount equal to the assessment rate times the reported
542 number of days. The agency shall collect, and each facility
543 shall pay, the quality assessment each month. The agency shall
544 collect the assessment from nursing home facility providers by
545 ~~no later than~~ the 15th day of the next succeeding calendar
546 month. The agency shall notify providers of the quality
547 assessment and provide a standardized form to complete and
548 submit with payments. The collection of the nursing home
549 facility quality assessment shall commence no sooner than 5 days
550 after the agency's initial payment of the Medicaid rates
551 containing the elements prescribed in subsection (4). Nursing

20112144e2

552 home facilities may not create a separate line-item charge for
553 the purpose of passing ~~through~~ the assessment through to
554 residents.

555 (3)

556 (d) Effective July 1, 2011 ~~2009~~, the agency may exempt from
557 the quality assessment or apply a lower quality assessment rate
558 to a qualified public, nonstate-owned or operated nursing home
559 facility whose total annual indigent census days are greater
560 than 20 ~~25~~ percent of the facility's total annual census days.

561 Section 7. Subsection (8) of section 409.9083, Florida
562 Statutes, is amended to read:

563 409.9083 Quality assessment on privately operated
564 intermediate care facilities for the developmentally disabled;
565 exemptions; purpose; federal approval required; remedies.—

566 ~~(8) This section is repealed October 1, 2011.~~

567 Section 8. Paragraph (a) of subsection (2) of section
568 409.911, Florida Statutes, is amended, and paragraph (d) is
569 added to subsection (4) of that section, to read:

570 409.911 Disproportionate share program.—Subject to specific
571 allocations established within the General Appropriations Act
572 and any limitations established pursuant to chapter 216, the
573 agency shall distribute, pursuant to this section, moneys to
574 hospitals providing a disproportionate share of Medicaid or
575 charity care services by making quarterly Medicaid payments as
576 required. Notwithstanding the provisions of s. 409.915, counties
577 are exempt from contributing toward the cost of this special
578 reimbursement for hospitals serving a disproportionate share of
579 low-income patients.

580 (2) The Agency for Health Care Administration shall use the

20112144e2

581 following actual audited data to determine the Medicaid days and
582 charity care to be used in calculating the disproportionate
583 share payment:

584 (a) The average of the 2004, 2005, and 2006 ~~2003, 2004, and~~
585 ~~2005~~ audited disproportionate share data to determine each
586 hospital's Medicaid days and charity care for the 2011-2012
587 ~~2010-2011~~ state fiscal year.

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

590 (d) Any nonstate government owned or operated hospital
591 eligible for payments under this section on July 1, 2011,
592 remains eligible for payments during the 2011-2012 state fiscal
593 year.

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

596 409.9112 Disproportionate share program for regional
597 perinatal intensive care centers.—In addition to the payments
598 made under s. 409.911, the agency shall design and implement a
599 system for making disproportionate share payments to those
600 hospitals that participate in the regional perinatal intensive
601 care center program established pursuant to chapter 383. The
602 system of payments must conform to federal requirements and
603 distribute funds in each fiscal year for which an appropriation
604 is made by making quarterly Medicaid payments. Notwithstanding
605 s. 409.915, counties are exempt from contributing toward the
606 cost of this special reimbursement for hospitals serving a
607 disproportionate share of low-income patients. For the 2011-2012
608 ~~2010-2011~~ state fiscal year, the agency may not distribute
609 moneys under the regional perinatal intensive care centers

20112144e2

610 disproportionate share program.

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

614

615
$$\text{TAE} = \text{HDSP} / \text{THDSP}$$

616

617 Where:

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

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

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

626

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

630

631
$$\text{TAP} = \text{TAE} \times \text{TA}$$

632

633 Where:

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

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

638 TA = total appropriation for the regional perinatal

20112144e2

639 intensive care center disproportionate share program.

640

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

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

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

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

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

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

666 (f) Agree to sponsor a program of continuing education in
667 perinatal care for health care professionals within the region

20112144e2

668 of the hospital, as specified by rule.

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

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

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

686 Section 10. Section 409.9113, Florida Statutes, is amended
687 to read:

688 409.9113 Disproportionate share program for teaching
689 hospitals.—In addition to the payments made under ss. 409.911
690 and 409.9112, the agency shall make disproportionate share
691 payments to ~~statutorily defined~~ teaching hospitals, as defined
692 in s. 408.07, for their increased costs associated with medical
693 education programs and for tertiary health care services
694 provided to the indigent. This system of payments must conform
695 to federal requirements and distribute funds in each fiscal year
696 for which an appropriation is made by making quarterly Medicaid

20112144e2

697 payments. Notwithstanding s. 409.915, counties are exempt from
698 contributing toward the cost of this special reimbursement for
699 hospitals serving a disproportionate share of low-income
700 patients. For the 2011-2012 ~~2010-2011~~ state fiscal year, the
701 agency shall distribute the moneys provided in the General
702 Appropriations Act to statutorily defined teaching hospitals and
703 family practice teaching hospitals, as defined in s. 395.805,
704 pursuant to this section ~~under the teaching hospital~~
705 ~~disproportionate share program~~. The funds provided for
706 statutorily defined teaching hospitals shall be distributed ~~in~~
707 ~~the same proportion as the state fiscal year 2003-2004 teaching~~
708 ~~hospital disproportionate share funds were distributed or as~~
709 ~~otherwise~~ provided in the General Appropriations Act. The funds
710 provided for family practice teaching hospitals shall be
711 distributed equally among family practice teaching hospitals.

712 (1) On or before September 15 of each year, the agency
713 shall calculate an allocation fraction to be used for
714 distributing funds to ~~state~~ statutory teaching hospitals.
715 Subsequent to the end of each quarter of the state fiscal year,
716 the agency shall distribute to each statutory teaching hospital,
717 ~~as defined in s. 408.07,~~ an amount determined by multiplying
718 one-fourth of the funds appropriated for this purpose by the
719 Legislature times such hospital's allocation fraction. The
720 allocation fraction for each such hospital shall be determined
721 by the sum of the following three primary factors, divided by
722 three:

723 (a) The number of nationally accredited graduate medical
724 education programs offered by the hospital, including programs
725 accredited by the Accreditation Council for Graduate Medical

20112144e2

726 Education and the combined Internal Medicine and Pediatrics
727 programs acceptable to both the American Board of Internal
728 Medicine and the American Board of Pediatrics at the beginning
729 of the state fiscal year preceding the date on which the
730 allocation fraction is calculated. The numerical value of this
731 factor is the fraction that the hospital represents of the total
732 number of programs, where the total is computed for all ~~state~~
733 statutory teaching hospitals.

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

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

746 2. The number of medical students enrolled in accredited
747 colleges of medicine and engaged in clinical activities,
748 including required clinical clerkships and clinical electives.
749 Full-time equivalents are computed using the fraction of the
750 year during which each trainee is primarily assigned to the
751 given institution, over the course of the state fiscal year
752 preceding the date on which the allocation fraction is
753 calculated. The numerical value of this factor is the fraction
754 that the given hospital represents of the total number of full-

20112144e2

755 time equivalent students enrolled in accredited colleges of
756 medicine, where the total is computed for all ~~state~~ statutory
757 teaching hospitals.

758

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

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

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

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

782 3. Total Medicaid payments to each hospital for direct
783 inpatient and outpatient services during the fiscal year

20112144e2

784 preceding the date on which the allocation factor is calculated.
 785 This includes payments made to each hospital for such services
 786 by Medicaid prepaid health plans, whether the plan was
 787 administered by the hospital or not. The numerical value of this
 788 factor is the fraction that each hospital represents of the
 789 total of such Medicaid payments, where the total is computed for
 790 all ~~state~~ statutory teaching hospitals.

791
 792 The primary factor for the service index is computed as the sum
 793 of these three components, divided by three.

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

798
 799
$$\text{TAP} = \text{THAF} \times \text{A}$$

800

801 Where:

802 TAP = total additional payment.

803 THAF = teaching hospital allocation factor.

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

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

808 409.9117 Primary care disproportionate share program.—For
 809 the 2011-2012 ~~2010-2011~~ state fiscal year, the agency shall not
 810 distribute moneys under the primary care disproportionate share
 811 program.

812 (1) If federal funds are available for disproportionate

20112144e2

813 share programs in addition to those otherwise provided by law,
814 ~~there shall be created a primary care disproportionate share~~
815 program shall be established.

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

819

$$820 \qquad \qquad \qquad \text{TAE} = \text{HDSP}/\text{THDSP}$$

821

822 Where:

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

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

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

829

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

833

$$834 \qquad \qquad \qquad \text{TAP} = \text{TAE} \times \text{TA}$$

835

836 Where:

837 TAP = total additional payment for a primary care hospital.

838 TAE = total amount earned by a primary care hospital.

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

841

20112144e2

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

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

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

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

863 (d) Contract with any federally qualified health center, if
864 one exists within the agreed geopolitical boundaries, concerning
865 the provision of primary care services, in order to guarantee
866 delivery of services in a nonduplicative fashion, and to provide
867 for referral arrangements, privileges, and admissions, as
868 appropriate. The hospital shall agree to provide ~~at an onsite or~~
869 ~~offsite facility~~ primary care services within 24 hours at an
870 onsite or offsite facility to which all Medicaid recipients and

20112144e2

871 persons eligible under this paragraph who do not require
872 emergency room services are referred during normal daylight
873 hours.

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

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

885 (g) Provide inpatient services to residents within the area
886 who are not eligible for Medicaid or Medicare, and who do not
887 have private health insurance, regardless of ability to pay, on
888 the basis of available space, except that hospitals may not be
889 prevented from establishing bill collection programs based on
890 ability to pay.

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

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

20112144e2

900 health services.

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

906

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

911 Section 12. Paragraph (b) of subsection (4), paragraph (b)
912 of subsection (16), and paragraph (a) of subsection (39) of
913 section 409.912, Florida Statutes, are amended to read:

914 409.912 Cost-effective purchasing of health care.—The
915 agency shall purchase goods and services for Medicaid recipients
916 in the most cost-effective manner consistent with the delivery
917 of quality medical care. To ensure that medical services are
918 effectively utilized, the agency may, in any case, require a
919 confirmation or second physician's opinion of the correct
920 diagnosis for purposes of authorizing future services under the
921 Medicaid program. This section does not restrict access to
922 emergency services or poststabilization care services as defined
923 in 42 C.F.R. part 438.114. Such confirmation or second opinion
924 shall be rendered in a manner approved by the agency. The agency
925 shall maximize the use of prepaid per capita and prepaid
926 aggregate fixed-sum basis services when appropriate and other
927 alternative service delivery and reimbursement methodologies,
928 including competitive bidding pursuant to s. 287.057, designed

20112144e2

929 to facilitate the cost-effective purchase of a case-managed
930 continuum of care. The agency shall also require providers to
931 minimize the exposure of recipients to the need for acute
932 inpatient, custodial, and other institutional care and the
933 inappropriate or unnecessary use of high-cost services. The
934 agency shall contract with a vendor to monitor and evaluate the
935 clinical practice patterns of providers in order to identify
936 trends that are outside the normal practice patterns of a
937 provider's professional peers or the national guidelines of a
938 provider's professional association. The vendor must be able to
939 provide information and counseling to a provider whose practice
940 patterns are outside the norms, in consultation with the agency,
941 to improve patient care and reduce inappropriate utilization.
942 The agency may mandate prior authorization, drug therapy
943 management, or disease management participation for certain
944 populations of Medicaid beneficiaries, certain drug classes, or
945 particular drugs to prevent fraud, abuse, overuse, and possible
946 dangerous drug interactions. The Pharmaceutical and Therapeutics
947 Committee shall make recommendations to the agency on drugs for
948 which prior authorization is required. The agency shall inform
949 the Pharmaceutical and Therapeutics Committee of its decisions
950 regarding drugs subject to prior authorization. The agency is
951 authorized to limit the entities it contracts with or enrolls as
952 Medicaid providers by developing a provider network through
953 provider credentialing. The agency may competitively bid single-
954 source-provider contracts if procurement of goods or services
955 results in demonstrated cost savings to the state without
956 limiting access to care. The agency may limit its network based
957 on the assessment of beneficiary access to care, provider

20112144e2

958 availability, provider quality standards, time and distance
959 standards for access to care, the cultural competence of the
960 provider network, demographic characteristics of Medicaid
961 beneficiaries, practice and provider-to-beneficiary standards,
962 appointment wait times, beneficiary use of services, provider
963 turnover, provider profiling, provider licensure history,
964 previous program integrity investigations and findings, peer
965 review, provider Medicaid policy and billing compliance records,
966 clinical and medical record audits, and other factors. Providers
967 shall not be entitled to enrollment in the Medicaid provider
968 network. The agency shall determine instances in which allowing
969 Medicaid beneficiaries to purchase durable medical equipment and
970 other goods is less expensive to the Medicaid program than long-
971 term rental of the equipment or goods. The agency may establish
972 rules to facilitate purchases in lieu of long-term rentals in
973 order to protect against fraud and abuse in the Medicaid program
974 as defined in s. 409.913. The agency may seek federal waivers
975 necessary to administer these policies.

976 (4) The agency may contract with:

977 (b) An entity that is providing comprehensive behavioral
978 health care services to certain Medicaid recipients through a
979 capitated, prepaid arrangement pursuant to the federal waiver
980 provided for by s. 409.905(5). Such entity must be licensed
981 under chapter 624, chapter 636, or chapter 641, or authorized
982 under paragraph (c) or paragraph (d), and must possess the
983 clinical systems and operational competence to manage risk and
984 provide comprehensive behavioral health care to Medicaid
985 recipients. As used in this paragraph, the term "comprehensive
986 behavioral health care services" means covered mental health and

20112144e2

987 substance abuse treatment services that are available to
988 Medicaid recipients. The Secretary of the Department of Children
989 and Family Services shall approve provisions of procurements
990 related to children in the department's care or custody before
991 enrolling such children in a prepaid behavioral health plan. Any
992 contract awarded under this paragraph must be competitively
993 procured. In developing The behavioral health care prepaid plan
994 procurement document, the agency shall ensure that the
995 procurement document requires the contractor to develop and
996 implement a plan to ensure compliance with s. 394.4574 related
997 to services provided to residents of licensed assisted living
998 facilities that hold a limited mental health license. Except as
999 provided in subparagraph 8., and except in counties where the
1000 Medicaid managed care pilot program is authorized pursuant to s.
1001 409.91211, the agency shall seek federal approval to contract
1002 with a single entity meeting these requirements to provide
1003 comprehensive behavioral health care services to all Medicaid
1004 recipients not enrolled in a Medicaid managed care plan
1005 authorized under s. 409.91211, a provider service network
1006 authorized under paragraph (d), or a Medicaid health maintenance
1007 organization in an AHCA area. In an AHCA area where the Medicaid
1008 managed care pilot program is authorized pursuant to s.
1009 409.91211 in one or more counties, the agency may procure a
1010 contract with a single entity to serve the remaining counties as
1011 an AHCA area or the remaining counties may be included with an
1012 adjacent AHCA area and are subject to this paragraph. Each
1013 entity must offer a sufficient choice of providers in its
1014 network to ensure recipient access to care and the opportunity
1015 to select a provider with whom they are satisfied. The network

20112144e2

1016 shall include all public mental health hospitals. To ensure
1017 unimpaired access to behavioral health care services by Medicaid
1018 recipients, all contracts issued pursuant to this paragraph must
1019 require 80 percent of the capitation paid to the managed care
1020 plan, including health maintenance organizations and capitated
1021 provider service networks, to be expended for the provision of
1022 behavioral health care services. If the managed care plan
1023 expends less than 80 percent of the capitation paid for the
1024 provision of behavioral health care services, the difference
1025 shall be returned to the agency. The agency shall provide the
1026 plan with a certification letter indicating the amount of
1027 capitation paid during each calendar year for behavioral health
1028 care services pursuant to this section. The agency may reimburse
1029 for substance abuse treatment services on a fee-for-service
1030 basis until the agency finds that adequate funds are available
1031 for capitated, prepaid arrangements.

1032 1. By January 1, 2001, The agency shall modify the
1033 contracts with the entities providing comprehensive inpatient
1034 and outpatient mental health care services to Medicaid
1035 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
1036 Counties, to include substance abuse treatment services.

1037 2. By July 1, 2003, the agency and the Department of
1038 Children and Family Services shall execute a written agreement
1039 that requires collaboration and joint development of all policy,
1040 budgets, procurement documents, contracts, and monitoring plans
1041 that have an impact on the state and Medicaid community mental
1042 health and targeted case management programs.

1043 3. Except as provided in subparagraph 8., by July 1, 2006,
1044 the agency and the Department of Children and Family Services

20112144e2

1045 shall contract with managed care entities in each AHCA area
1046 except area 6 or arrange to provide comprehensive inpatient and
1047 outpatient mental health and substance abuse services through
1048 capitated prepaid arrangements to all Medicaid recipients who
1049 are eligible to participate in such plans under federal law and
1050 regulation. In AHCA areas where eligible individuals number less
1051 than 150,000, the agency shall contract with a single managed
1052 care plan to provide comprehensive behavioral health services to
1053 all recipients who are not enrolled in a Medicaid health
1054 maintenance organization, a provider service network authorized
1055 under paragraph (d), or a Medicaid capitated managed care plan
1056 authorized under s. 409.91211. The agency may contract with more
1057 than one comprehensive behavioral health provider to provide
1058 care to recipients who are not enrolled in a Medicaid capitated
1059 managed care plan authorized under s. 409.91211, a provider
1060 service network authorized under paragraph (d), or a Medicaid
1061 health maintenance organization in AHCA areas where the eligible
1062 population exceeds 150,000. In an AHCA area where the Medicaid
1063 managed care pilot program is authorized pursuant to s.
1064 409.91211 in one or more counties, the agency may procure a
1065 contract with a single entity to serve the remaining counties as
1066 an AHCA area or the remaining counties may be included with an
1067 adjacent AHCA area and shall be subject to this paragraph.
1068 Contracts for comprehensive behavioral health providers awarded
1069 pursuant to this section shall be competitively procured. Both
1070 for-profit and not-for-profit corporations are eligible to
1071 compete. Managed care plans contracting with the agency under
1072 subsection (3) or paragraph (d), shall provide and receive
1073 payment for the same comprehensive behavioral health benefits as

20112144e2

1074 provided in AHCA rules, including handbooks incorporated by
1075 reference. In AHCA area 11, the agency shall contract with at
1076 least two comprehensive behavioral health care providers to
1077 provide behavioral health care to recipients in that area who
1078 are enrolled in, or assigned to, the MediPass program. One of
1079 the behavioral health care contracts must be with the existing
1080 provider service network pilot project, as described in
1081 paragraph (d), for the purpose of demonstrating the cost-
1082 effectiveness of the provision of quality mental health services
1083 through a public hospital-operated managed care model. Payment
1084 shall be at an agreed-upon capitated rate to ensure cost
1085 savings. Of the recipients in area 11 who are assigned to
1086 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
1087 MediPass-enrolled recipients shall be assigned to the existing
1088 provider service network in area 11 for their behavioral care.

1089 4. By October 1, 2003, the agency and the department shall
1090 submit a plan to the Governor, the President of the Senate, and
1091 the Speaker of the House of Representatives which provides for
1092 the full implementation of capitated prepaid behavioral health
1093 care in all areas of the state.

1094 a. Implementation shall begin in 2003 in those AHCA areas
1095 of the state where the agency is able to establish sufficient
1096 capitation rates.

1097 b. If the agency determines that the proposed capitation
1098 rate in any area is insufficient to provide appropriate
1099 services, the agency may adjust the capitation rate to ensure
1100 that care will be available. The agency and the department may
1101 use existing general revenue to address any additional required
1102 match but may not over-obligate existing funds on an annualized

20112144e2

1103 basis.

1104 c. Subject to any limitations provided in the General
1105 Appropriations Act, the agency, in compliance with appropriate
1106 federal authorization, shall develop policies and procedures
1107 that allow for certification of local and state funds.

1108 5. Children residing in a statewide inpatient psychiatric
1109 program, or in a Department of Juvenile Justice or a Department
1110 of Children and Family Services residential program approved as
1111 a Medicaid behavioral health overlay services provider may not
1112 be included in a behavioral health care prepaid health plan or
1113 any other Medicaid managed care plan pursuant to this paragraph.

1114 6. In converting to a prepaid system of delivery, the
1115 agency shall in its procurement document require an entity
1116 providing only comprehensive behavioral health care services to
1117 prevent the displacement of indigent care patients by enrollees
1118 in the Medicaid prepaid health plan providing behavioral health
1119 care services from facilities receiving state funding to provide
1120 indigent behavioral health care, to facilities licensed under
1121 chapter 395 which do not receive state funding for indigent
1122 behavioral health care, or reimburse the unsubsidized facility
1123 for the cost of behavioral health care provided to the displaced
1124 indigent care patient.

1125 7. Traditional community mental health providers under
1126 contract with the Department of Children and Family Services
1127 pursuant to part IV of chapter 394, child welfare providers
1128 under contract with the Department of Children and Family
1129 Services in areas 1 and 6, and inpatient mental health providers
1130 licensed pursuant to chapter 395 must be offered an opportunity
1131 to accept or decline a contract to participate in any provider

20112144e2

1132 network for prepaid behavioral health services.

1133 8. All Medicaid-eligible children, except children in area
1134 1 and children in Highlands County, Hardee County, Polk County,
1135 or Manatee County of area 6, that are open for child welfare
1136 services in the HomeSafeNet system, shall receive their
1137 behavioral health care services through a specialty prepaid plan
1138 operated by community-based lead agencies through a single
1139 agency or formal agreements among several agencies. The agency
1140 shall work with the specialty plan to develop clinically
1141 effective, evidence-based alternatives as a downward
1142 substitution for the statewide inpatient psychiatric program and
1143 similar residential care and institutional services. The
1144 specialty prepaid plan must result in savings to the state
1145 comparable to savings achieved in other Medicaid managed care
1146 and prepaid programs. Such plan must provide mechanisms to
1147 maximize state and local revenues. The specialty prepaid plan
1148 shall be developed by the agency and the Department of Children
1149 and Family Services. The agency may seek federal waivers to
1150 implement this initiative. Medicaid-eligible children whose
1151 cases are open for child welfare services in the HomeSafeNet
1152 system and who reside in AHCA area 10 are exempt from the
1153 specialty prepaid plan upon the development of a service
1154 delivery mechanism for children who reside in area 10 as
1155 specified in s. 409.91211(3)(dd).

1156 (16)

1157 (b) The responsibility of the agency under this subsection
1158 includes ~~shall include~~ the development of capabilities to
1159 identify actual and optimal practice patterns; patient and
1160 provider educational initiatives; methods for determining

20112144e2

1161 patient compliance with prescribed treatments; fraud, waste, and
1162 abuse prevention and detection programs; and beneficiary case
1163 management programs.

1164 1. The practice pattern identification program shall
1165 evaluate practitioner prescribing patterns based on national and
1166 regional practice guidelines, comparing practitioners to their
1167 peer groups. The agency and its Drug Utilization Review Board
1168 shall consult with the Department of Health and a panel of
1169 practicing health care professionals consisting of the
1170 following: the Speaker of the House of Representatives and the
1171 President of the Senate shall each appoint three physicians
1172 licensed under chapter 458 or chapter 459; and the Governor
1173 shall appoint two pharmacists licensed under chapter 465 and one
1174 dentist licensed under chapter 466 who is an oral surgeon. Terms
1175 of the panel members shall expire at the discretion of the
1176 appointing official. The advisory panel shall be responsible for
1177 evaluating treatment guidelines and recommending ways to
1178 incorporate their use in the practice pattern identification
1179 program. Practitioners who are prescribing inappropriately or
1180 inefficiently, as determined by the agency, may have their
1181 prescribing of certain drugs subject to prior authorization or
1182 may be terminated from all participation in the Medicaid
1183 program.

1184 2. The agency shall also develop educational interventions
1185 designed to promote the proper use of medications by providers
1186 and beneficiaries.

1187 3. The agency shall implement a pharmacy fraud, waste, and
1188 abuse initiative that may include a surety bond or letter of
1189 credit requirement for participating pharmacies, enhanced

20112144e2

1190 provider auditing practices, the use of additional fraud and
1191 abuse software, recipient management programs for beneficiaries
1192 inappropriately using their benefits, and other steps that ~~will~~
1193 eliminate provider and recipient fraud, waste, and abuse. The
1194 initiative shall address enforcement efforts to reduce the
1195 number and use of counterfeit prescriptions.

1196 4. ~~By September 30, 2002,~~ The agency may ~~shall~~ contract
1197 with an entity in the state to provide Medicaid providers with
1198 electronic access to Medicaid prescription refill data and
1199 information relating to the Medicaid preferred drug list
1200 ~~implement a wireless handheld clinical pharmacology drug~~
1201 ~~information database for practitioners~~. The initiative shall be
1202 designed to enhance the agency's efforts to reduce fraud, abuse,
1203 and errors in the prescription drug benefit program and to
1204 otherwise further the intent of this paragraph.

1205 5. ~~By April 1, 2006,~~ The agency shall contract with an
1206 entity to design a database of clinical utilization information
1207 or electronic medical records for Medicaid providers. The
1208 database ~~This system~~ must be web-based and allow providers to
1209 review on a real-time basis the utilization of Medicaid
1210 services, including, but not limited to, physician office
1211 visits, inpatient and outpatient hospitalizations, laboratory
1212 and pathology services, radiological and other imaging services,
1213 dental care, and patterns of dispensing prescription drugs in
1214 order to coordinate care and identify potential fraud and abuse.

1215 6. The agency may apply for any federal waivers needed to
1216 administer this paragraph.

1217 (39) (a) The agency shall implement a Medicaid prescribed-
1218 drug spending-control program that includes the following

20112144e2

1219 components:

1220 1. A Medicaid preferred drug list, which shall be a listing
1221 of cost-effective therapeutic options recommended by the
1222 Medicaid Pharmacy and Therapeutics Committee established
1223 pursuant to s. 409.91195 and adopted by the agency for each
1224 therapeutic class on the preferred drug list. At the discretion
1225 of the committee, and when feasible, the preferred drug list
1226 should include at least two products in a therapeutic class. The
1227 agency may post the preferred drug list and updates to the
1228 ~~preferred drug~~ list on an Internet website without following the
1229 rulemaking procedures of chapter 120. Antiretroviral agents are
1230 excluded from the preferred drug list. The agency shall also
1231 limit the amount of a prescribed drug dispensed to no more than
1232 a 34-day supply unless the drug products' smallest marketed
1233 package is greater than a 34-day supply, or the drug is
1234 determined by the agency to be a maintenance drug in which case
1235 a 100-day maximum supply may be authorized. The agency may ~~is~~
1236 ~~authorized to~~ seek any federal waivers necessary to implement
1237 these cost-control programs and to continue participation in the
1238 federal Medicaid rebate program, or alternatively to negotiate
1239 state-only manufacturer rebates. The agency may adopt rules to
1240 administer ~~implement~~ this subparagraph. The agency shall
1241 continue to provide unlimited contraceptive drugs and items. The
1242 agency must establish procedures to ensure that:

1243 a. There is a response to a request for prior consultation
1244 by telephone or other telecommunication device within 24 hours
1245 after receipt of a request for prior consultation; and

1246 b. A 72-hour supply of the drug prescribed is provided in
1247 an emergency or when the agency does not provide a response

20112144e2

1248 within 24 hours as required by sub-subparagraph a.

1249 2. Reimbursement to pharmacies for Medicaid prescribed
1250 drugs shall be set at the lowest ~~lesser~~ of: the average
1251 wholesale price (AWP) minus 16.4 percent, the wholesaler
1252 acquisition cost (WAC) plus 1.5 ~~4.75~~ percent, the federal upper
1253 limit (FUL), the state maximum allowable cost (SMAC), or the
1254 usual and customary (UAC) charge billed by the provider.

1255 3. The agency shall develop and implement a process for
1256 managing the drug therapies of Medicaid recipients who are using
1257 significant numbers of prescribed drugs each month. The
1258 management process may include, but is not limited to,
1259 comprehensive, physician-directed medical-record reviews, claims
1260 analyses, and case evaluations to determine the medical
1261 necessity and appropriateness of a patient's treatment plan and
1262 drug therapies. The agency may contract with a private
1263 organization to provide drug-program-management services. The
1264 Medicaid drug benefit management program shall include
1265 initiatives to manage drug therapies for HIV/AIDS patients,
1266 patients using 20 or more unique prescriptions in a 180-day
1267 period, and the top 1,000 patients in annual spending. The
1268 agency shall enroll any Medicaid recipient in the drug benefit
1269 management program if he or she meets the specifications of this
1270 provision and is not enrolled in a Medicaid health maintenance
1271 organization.

1272 4. The agency may limit the size of its pharmacy network
1273 based on need, competitive bidding, price negotiations,
1274 credentialing, or similar criteria. The agency shall give
1275 special consideration to rural areas in determining the size and
1276 location of pharmacies included in the Medicaid pharmacy

20112144e2

1277 network. A pharmacy credentialing process may include criteria
1278 such as a pharmacy's full-service status, location, size,
1279 patient educational programs, patient consultation, disease
1280 management services, and other characteristics. The agency may
1281 impose a moratorium on Medicaid pharmacy enrollment if ~~when~~ it
1282 is determined that it has a sufficient number of Medicaid-
1283 participating providers. The agency must allow dispensing
1284 practitioners to participate as a part of the Medicaid pharmacy
1285 network regardless of the practitioner's proximity to any other
1286 entity that is dispensing prescription drugs under the Medicaid
1287 program. A dispensing practitioner must meet all credentialing
1288 requirements applicable to his or her practice, as determined by
1289 the agency.

1290 5. The agency shall develop and implement a program that
1291 requires Medicaid practitioners who prescribe drugs to use a
1292 counterfeit-proof prescription pad for Medicaid prescriptions.
1293 The agency shall require the use of standardized counterfeit-
1294 proof prescription pads by Medicaid-participating prescribers or
1295 prescribers who write prescriptions for Medicaid recipients. The
1296 agency may implement the program in targeted geographic areas or
1297 statewide.

1298 6. The agency may enter into arrangements that require
1299 manufacturers of generic drugs prescribed to Medicaid recipients
1300 to provide rebates of at least 15.1 percent of the average
1301 manufacturer price for the manufacturer's generic products.
1302 These arrangements shall require that if a generic-drug
1303 manufacturer pays federal rebates for Medicaid-reimbursed drugs
1304 at a level below 15.1 percent, the manufacturer must provide a
1305 supplemental rebate to the state in an amount necessary to

20112144e2

1306 achieve a 15.1-percent rebate level.

1307 7. The agency may establish a preferred drug list as
1308 described in this subsection, and, pursuant to the establishment
1309 of such preferred drug list, ~~it is authorized to~~ negotiate
1310 supplemental rebates from manufacturers that are in addition to
1311 those required by Title XIX of the Social Security Act and at no
1312 less than 14 percent of the average manufacturer price as
1313 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
1314 the federal or supplemental rebate, or both, equals or exceeds
1315 29 percent. There is no upper limit on the supplemental rebates
1316 the agency may negotiate. The agency may determine that specific
1317 products, brand-name or generic, are competitive at lower rebate
1318 percentages. Agreement to pay the minimum supplemental rebate
1319 percentage ~~will~~ guarantee a manufacturer that the Medicaid
1320 Pharmaceutical and Therapeutics Committee will consider a
1321 product for inclusion on the preferred drug list. However, a
1322 pharmaceutical manufacturer is not guaranteed placement on the
1323 preferred drug list by simply paying the minimum supplemental
1324 rebate. Agency decisions will be made on the clinical efficacy
1325 of a drug and recommendations of the Medicaid Pharmaceutical and
1326 Therapeutics Committee, as well as the price of competing
1327 products minus federal and state rebates. The agency may ~~is~~
1328 ~~authorized to~~ contract with an outside agency or contractor to
1329 conduct negotiations for supplemental rebates. For the purposes
1330 of this section, the term "supplemental rebates" means cash
1331 rebates. ~~Effective July 1, 2004,~~ Value-added programs as a
1332 substitution for supplemental rebates are prohibited. The agency
1333 may ~~is authorized to~~ seek any federal waivers to implement this
1334 initiative.

20112144e2

1335 8. The agency ~~for Health Care Administration~~ shall expand
1336 home delivery of pharmacy products. The agency may amend the
1337 state plan and issue a procurement, as necessary, in order to
1338 implement this program. The procurements must include agreements
1339 with a pharmacy or pharmacies located in the state to provide
1340 mail order delivery services at no cost to the recipients who
1341 elect to receive home delivery of pharmacy products. The
1342 procurement must focus on serving recipients with chronic
1343 diseases for which pharmacy expenditures represent a significant
1344 portion of Medicaid pharmacy expenditures or which impact a
1345 significant portion of the Medicaid population. ~~To assist~~
1346 ~~Medicaid patients in securing their prescriptions and reduce~~
1347 ~~program costs, the agency shall expand its current mail-order-~~
1348 ~~pharmacy diabetes supply program to include all generic and~~
1349 ~~brand-name drugs used by Medicaid patients with diabetes.~~
1350 ~~Medicaid recipients in the current program may obtain~~
1351 ~~nondiabetes drugs on a voluntary basis. This initiative is~~
1352 ~~limited to the geographic area covered by the current contract.~~
1353 The agency may seek and implement any federal waivers necessary
1354 to implement this subparagraph.

1355 9. The agency shall limit to one dose per month any drug
1356 prescribed to treat erectile dysfunction.

1357 10.a. The agency may implement a Medicaid behavioral drug
1358 management system. The agency may contract with a vendor that
1359 has experience in operating behavioral drug management systems
1360 to implement this program. The agency may ~~is authorized to~~ seek
1361 federal waivers to implement this program.

1362 b. The agency, in conjunction with the Department of
1363 Children and Family Services, may implement the Medicaid

20112144e2

1364 behavioral drug management system that is designed to improve
1365 the quality of care and behavioral health prescribing practices
1366 based on best practice guidelines, improve patient adherence to
1367 medication plans, reduce clinical risk, and lower prescribed
1368 drug costs and the rate of inappropriate spending on Medicaid
1369 behavioral drugs. The program may include the following
1370 elements:

1371 (I) Provide for the development and adoption of best
1372 practice guidelines for behavioral health-related drugs such as
1373 antipsychotics, antidepressants, and medications for treating
1374 bipolar disorders and other behavioral conditions; translate
1375 them into practice; review behavioral health prescribers and
1376 compare their prescribing patterns to a number of indicators
1377 that are based on national standards; and determine deviations
1378 from best practice guidelines.

1379 (II) Implement processes for providing feedback to and
1380 educating prescribers using best practice educational materials
1381 and peer-to-peer consultation.

1382 (III) Assess Medicaid beneficiaries who are outliers in
1383 their use of behavioral health drugs with regard to the numbers
1384 and types of drugs taken, drug dosages, combination drug
1385 therapies, and other indicators of improper use of behavioral
1386 health drugs.

1387 (IV) Alert prescribers to patients who fail to refill
1388 prescriptions in a timely fashion, are prescribed multiple same-
1389 class behavioral health drugs, and may have other potential
1390 medication problems.

1391 (V) Track spending trends for behavioral health drugs and
1392 deviation from best practice guidelines.

20112144e2

1393 (VI) Use educational and technological approaches to
1394 promote best practices, educate consumers, and train prescribers
1395 in the use of practice guidelines.

1396 (VII) Disseminate electronic and published materials.

1397 (VIII) Hold statewide and regional conferences.

1398 (IX) Implement a disease management program with a model
1399 quality-based medication component for severely mentally ill
1400 individuals and emotionally disturbed children who are high
1401 users of care.

1402 11.~~a~~. The agency shall implement a Medicaid prescription
1403 drug management system.

1404 a. The agency may contract with a vendor that has
1405 experience in operating prescription drug management systems in
1406 order to implement this system. Any management system that is
1407 implemented in accordance with this subparagraph must rely on
1408 cooperation between physicians and pharmacists to determine
1409 appropriate practice patterns and clinical guidelines to improve
1410 the prescribing, dispensing, and use of drugs in the Medicaid
1411 program. The agency may seek federal waivers to implement this
1412 program.

1413 b. The drug management system must be designed to improve
1414 the quality of care and prescribing practices based on best
1415 practice guidelines, improve patient adherence to medication
1416 plans, reduce clinical risk, and lower prescribed drug costs and
1417 the rate of inappropriate spending on Medicaid prescription
1418 drugs. The program must:

1419 (I) Provide for the ~~development and~~ adoption of best
1420 practice guidelines for the prescribing and use of drugs in the
1421 Medicaid program, including translating best practice guidelines

20112144e2

1422 into practice; reviewing prescriber patterns and comparing them
1423 to indicators that are based on national standards and practice
1424 patterns of clinical peers in their community, statewide, and
1425 nationally; and determine deviations from best practice
1426 guidelines.

1427 (II) Implement processes for providing feedback to and
1428 educating prescribers using best practice educational materials
1429 and peer-to-peer consultation.

1430 (III) Assess Medicaid recipients who are outliers in their
1431 use of a single or multiple prescription drugs with regard to
1432 the numbers and types of drugs taken, drug dosages, combination
1433 drug therapies, and other indicators of improper use of
1434 prescription drugs.

1435 (IV) Alert prescribers to recipients ~~patients~~ who fail to
1436 refill prescriptions in a timely fashion, are prescribed
1437 multiple drugs that may be redundant or contraindicated, or may
1438 have other potential medication problems.

1439 ~~(V) Track spending trends for prescription drugs and
1440 deviation from best practice guidelines.~~

1441 ~~(VI) Use educational and technological approaches to
1442 promote best practices, educate consumers, and train prescribers
1443 in the use of practice guidelines.~~

1444 ~~(VII) Disseminate electronic and published materials.~~

1445 ~~(VIII) Hold statewide and regional conferences.~~

1446 ~~(IX) Implement disease management programs in cooperation
1447 with physicians and pharmacists, along with a model quality-
1448 based medication component for individuals having chronic
1449 medical conditions.~~

1450 12. The agency may ~~is authorized to~~ contract for drug

20112144e2

1451 rebate administration, including, but not limited to,
1452 calculating rebate amounts, invoicing manufacturers, negotiating
1453 disputes with manufacturers, and maintaining a database of
1454 rebate collections.

1455 13. The agency may specify the preferred daily dosing form
1456 or strength for the purpose of promoting best practices with
1457 regard to the prescribing of certain drugs as specified in the
1458 General Appropriations Act and ensuring cost-effective
1459 prescribing practices.

1460 14. The agency may require prior authorization for
1461 Medicaid-covered prescribed drugs. The agency may, ~~but is not~~
1462 ~~required to,~~ prior-authorize the use of a product:

- 1463 a. For an indication not approved in labeling;
1464 b. To comply with certain clinical guidelines; or
1465 c. If the product has the potential for overuse, misuse, or
1466 abuse.

1467
1468 The agency may require the prescribing professional to provide
1469 information about the rationale and supporting medical evidence
1470 for the use of a drug. The agency may post prior authorization
1471 criteria and protocol and updates to the list of drugs that are
1472 subject to prior authorization on an Internet website without
1473 amending its rule or engaging in additional rulemaking.

1474 15. The agency, in conjunction with the Pharmaceutical and
1475 Therapeutics Committee, may require age-related prior
1476 authorizations for certain prescribed drugs. The agency may
1477 preauthorize the use of a drug for a recipient who may not meet
1478 the age requirement or may exceed the length of therapy for use
1479 of this product as recommended by the manufacturer and approved

20112144e2

1480 by the Food and Drug Administration. Prior authorization may
1481 require the prescribing professional to provide information
1482 about the rationale and supporting medical evidence for the use
1483 of a drug.

1484 16. The agency shall implement a step-therapy prior
1485 authorization approval process for medications excluded from the
1486 preferred drug list. Medications listed on the preferred drug
1487 list must be used within the previous 12 months before ~~prior to~~
1488 the alternative medications that are not listed. The step-
1489 therapy prior authorization may require the prescriber to use
1490 the medications of a similar drug class or for a similar medical
1491 indication unless contraindicated in the Food and Drug
1492 Administration labeling. The trial period between the specified
1493 steps may vary according to the medical indication. The step-
1494 therapy approval process shall be developed in accordance with
1495 the committee as stated in s. 409.91195(7) and (8). A drug
1496 product may be approved without meeting the step-therapy prior
1497 authorization criteria if the prescribing physician provides the
1498 agency with additional written medical or clinical documentation
1499 that the product is medically necessary because:

1500 a. There is not a drug on the preferred drug list to treat
1501 the disease or medical condition which is an acceptable clinical
1502 alternative;

1503 b. The alternatives have been ineffective in the treatment
1504 of the beneficiary's disease; or

1505 c. Based on historic evidence and known characteristics of
1506 the patient and the drug, the drug is likely to be ineffective,
1507 or the number of doses have been ineffective.
1508

20112144e2

1509 The agency shall work with the physician to determine the best
1510 alternative for the patient. The agency may adopt rules waiving
1511 the requirements for written clinical documentation for specific
1512 drugs in limited clinical situations.

1513 17. The agency shall implement a return and reuse program
1514 for drugs dispensed by pharmacies to institutional recipients,
1515 which includes payment of a \$5 restocking fee for the
1516 implementation and operation of the program. The return and
1517 reuse program shall be implemented electronically and in a
1518 manner that promotes efficiency. The program must permit a
1519 pharmacy to exclude drugs from the program if it is not
1520 practical or cost-effective for the drug to be included and must
1521 provide for the return to inventory of drugs that cannot be
1522 credited or returned in a cost-effective manner. The agency
1523 shall determine if the program has reduced the amount of
1524 Medicaid prescription drugs which are destroyed on an annual
1525 basis and if there are additional ways to ensure more
1526 prescription drugs are not destroyed which could safely be
1527 reused. ~~The agency's conclusion and recommendations shall be~~
1528 ~~reported to the Legislature by December 1, 2005.~~

1529 Section 13. Paragraph (m) is added to subsection (2) and
1530 subsection (15) is added to section 409.9122, Florida Statutes,
1531 to read:

1532 409.9122 Mandatory Medicaid managed care enrollment;
1533 programs and procedures.—

1534 (2)

1535 (m) If the Medicaid recipient is diagnosed with HIV/AIDS
1536 and resides in Broward, Miami-Dade, or Palm Beach counties, the
1537 agency shall assign the recipient to a managed care plan that is

20112144e2

1538 a health maintenance organization authorized under Chapter 641,
1539 under contract with the agency on July 1, 2011, and which offers
1540 a delivery system through a university-based teaching and
1541 research-oriented organization that specializes in providing
1542 health care services and treatment for individuals diagnosed
1543 with HIV/AIDS.

1544 (15) The agency shall contract with a single provider
1545 service network to function as a managing entity for the
1546 MediPass program in all counties with fewer than two prepaid
1547 plans. The contractor shall be responsible for implementing
1548 preauthorization procedures, case management programs, and
1549 utilization management initiatives in order to improve care
1550 coordination and patient outcomes while reducing costs. The
1551 contractor may earn an administrative fee if the fee is less
1552 than any savings as determined by the reconciliation process
1553 under s. 409.912(4)(d)1.

1554 Section 14. Section 636.0145, Florida Statutes, is amended
1555 to read:

1556 636.0145 Certain entities contracting with Medicaid.—
1557 Notwithstanding the requirements of s. 409.912(4)(b), an entity
1558 that is providing comprehensive inpatient and outpatient mental
1559 health care services to certain Medicaid recipients in
1560 Hillsborough, Highlands, Hardee, Manatee, and Polk Counties
1561 through a capitated, prepaid arrangement pursuant to the federal
1562 waiver provided for in s. 409.905(5) must become licensed under
1563 chapter 636 by December 31, 1998. Any entity licensed under this
1564 chapter which provides services solely to Medicaid recipients
1565 under a contract with Medicaid is ~~shall be~~ exempt from ss.
1566 636.017, 636.018, 636.022, 636.028, ~~and~~ 636.034, and 636.066(1).

20112144e2

1567 Section 15. The amendments to s. 636.0145, Florida
1568 Statutes, under this act shall operate prospectively and do not
1569 provide a basis for relief from or assessment of taxes not paid,
1570 or for determining any denial of or right to a refund of taxes
1571 paid before the effective date of the act.

1572 Section 16. (1) The Legislature finds that hundreds of
1573 millions of dollars appropriated annually in support of the
1574 state's Medicaid program and other critical health programs come
1575 directly from revenues resulting from the settlement in *State of*
1576 *Florida v. American Tobacco Co.*, No. 95-1466AH (Fla. 15th Cir.
1577 Ct.), that maintaining those revenues is critical to the health
1578 of this state's residents, that s. 569.23(3), Florida Statutes,
1579 protects the continued receipt of those revenues, that the
1580 sunset of s. 569.23(3), Florida Statutes, will undermine
1581 financial support for the state's Medicaid and other critical
1582 health programs, and that the sunset of that subsection should
1583 therefore be repealed.

1584 (2) Paragraph (f) of subsection (3) of section 569.23,
1585 Florida Statutes, is repealed.

1586 Section 17. Notwithstanding s. 430.707, Florida Statutes,
1587 and subject to federal approval of the application to be a site
1588 for the Program of All-inclusive Care for the Elderly, the
1589 Agency for Health Care Administration shall contract with one
1590 private health care organization, the sole member of which is a
1591 private, not-for-profit corporation that owns and manages health
1592 care organizations which provide comprehensive long-term care
1593 services, including nursing home, assisted living, independent
1594 housing, home care, adult day care, and care management, with a
1595 board-certified, trained geriatrician as the medical director.

20112144e2

1596 This organization shall provide these services to frail and
1597 elderly persons who reside in Palm Beach County. The
1598 organization is exempt from the requirements of chapter 641,
1599 Florida Statutes. The agency, in consultation with the
1600 Department of Elderly Affairs and subject to an appropriation,
1601 shall approve up to 150 initial enrollees in the Program of All-
1602 inclusive Care for the Elderly established by this organization
1603 to serve elderly persons who reside in Palm Beach County.

1604 Section 18. This act shall take effect July 1, 2011.