CHAPTER 2011-61

Senate Bill No. 2144

An act relating to Medicaid; amending s. 400.23, F.S.; revising the minimum staffing requirements for nursing homes; amending s. 408.815, F.S.; requiring that the Agency for Health Care Administration deny an application for a license or license renewal of an applicant, a controlling interest of the applicant, or any entity in which a controlling interest of the applicant was an owner or officer during the occurrence of certain actions; authorizing the agency to consider certain mitigating circumstances; authorizing the agency to extend a license expiration date under certain circumstances; amending s. 409.904, F.S.; repealing the sunset of provisions authorizing the federal waiver for certain persons age 65 and older or who have a disability; repealing the sunset of provisions authorizing a specified medically needy program; eliminating the limit to services placed on the medically needy program for pregnant women and children younger than age 21; amending s. 409.905, F.S.; deleting provisions requiring that the agency implement hospitalist programs; amending s. 409.908, F.S.; revising the factors that are excluded from the direct care subcomponent of the long-term care reimbursement plan for nursing home care; revising the factors for calculating the maximum allowable fee for pharmaceutical ingredient costs; continuing the requirement that the Agency for Health Care Administration set certain institutional provider reimbursement rates in a manner that results in no automatic cost-based statewide expenditure increase; deleting an obsolete requirement to establish workgroups to evaluate alternate reimbursement and payment methods; eliminating the repeal date of the suspension of the use of cost data to set certain institutional provider reimbursement rates; amending s. 409.9082, F.S.; revising the aggregated amount of the quality assessment for nursing home facilities; exempting certain nursing home facilities from the quality assessment; amending s. 409.9083, F.S.; eliminating the repeal date of the quality assessment on privately operated intermediate care facilities for the developmentally disabled; amending s. 409.911, F.S.; updating references to data to be used for the disproportionate share program; providing that certain hospitals eligible for payments remain eligible for payments during the next fiscal year; amending s. 409.9112, F.S.; extending the prohibition against distributing moneys under the regional perinatal intensive care centers disproportionate share program for another year; amending s. 409.9113, F.S.; extending the disproportionate share program for teaching hospitals for another year; amending s. 409.9117, F.S.; extending the prohibition against distributing moneys under the primary care disproportionate share program for another year; amending s. 409.912, F.S.; providing for alternatives to the statewide inpatient psychiatric program; allowing the agency to continue to contract for electronic access to certain pharmacology drug information; eliminating the requirement to implement a wireless handheld clinical pharmacology drug information database for practitioners; revising the factors for

calculating the maximum allowable fee for pharmaceutical ingredient costs; deleting obsolete provisions; authorizing the agency to seek federal approval and to issue a procurement in order to implement a home delivery of pharmacy products program; establishing the provisions for the procurement and the program; eliminating the requirement for the expansion of the mail-order-pharmacy diabetes-supply program; eliminating certain provisions of the Medicaid prescription drug management program; amending s. 409.9122, F.S.; requiring the agency to assign Medicaid recipients with HIV/AIDS in certain counties to a certain type of managed care plan; requiring the agency to contract with a single provider service network to manage the MediPass program in certain counties; amending s. 636.0145, F.S.; exempting certain entities providing services solely to Medicaid recipients under a Medicaid contract from being subject to the premium tax imposed on premiums, contributions, and assessments received by prepaid limited health service organizations; providing for prospective operation and specifying that the act does not provide a basis for relief from or assessment of taxes not paid, or for determining any denial of or right to a refund of taxes paid, before the effective date of the act; providing legislative intent with respect to the need to maintain revenues that support critical health programs; repealing s. 569.23(3)(f), F.S.; abrogating the repeal of provisions requiring that appellants of tobacco settlement agreement judgments provide specified security; authorizing the agency to contract with an organization to provide certain benefits under a federal program in Palm Beach County; providing an exemption from ch. 641, F.S., for the organization; authorizing, subject to appropriation, enrollment slots for the Program of All-inclusive Care for the Elderly in Palm Beach County; providing an effective date.

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

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

400.23 Rules; evaluation and deficiencies; licensure status.—

(3)(a)1. The agency shall adopt rules providing minimum staffing requirements for nursing <u>home facilities</u> ~~homes~~. These requirements <u>must</u> ~~shall~~ include, for each ~~nursing home~~ facility:

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

b. A minimum certified nursing assistant staffing of <u>2.5</u> ~~2.7~~ hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents.

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

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

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

4. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if~~,~~ ~~provided that~~ the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and ~~that~~ the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. ~~In no event may~~ The hours of a licensed nurse with dual job responsibilities may not be counted twice.

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

408.815 License or application denial; revocation.—

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

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

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

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

(d) A demonstrated pattern of deficient performance.

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

(2) If a licensee lawfully continues to operate while a denial or revocation is pending in litigation, the licensee must continue to meet all other requirements of this part, authorizing statutes, and applicable rules and ~~must~~ file subsequent renewal applications for licensure and pay all licensure fees. The provisions of ss. 120.60(1) and 408.806(3)(c) do ~~shall~~ not apply to renewal applications filed during the time period in which the litigation of the denial or revocation is pending until that litigation is final.

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

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

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

(b) Termination ~~Terminated~~ for cause from the Medicare ~~Florida Medicaid~~ program or a state Medicaid program ~~pursuant to s. 409.913~~, unless the applicant has been in good standing with the Medicare program or a state ~~the Florida~~ Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.~~; or~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2)~~(a)~~ A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled. ~~This paragraph expires June 30, 2011.~~

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

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

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient

who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

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

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

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

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

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

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

(2)

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

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

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

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

4. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per

resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

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

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

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

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

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

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

(d) The agency may establish a supplemental pharmaceutical dispensing fee to be paid to providers returning unused unit-dose packaged medications to stock and crediting the Medicaid program for the ingredient cost of those

medications if the ingredient costs to be credited exceed the value of the supplemental dispensing fee.

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

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

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

1. Inpatient hospitals.

2. Outpatient hospitals.

3. Nursing homes.

4. County health departments.

5. Community intermediate care facilities for the developmentally disabled.

6. Prepaid health plans.

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

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

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

Section 6. Subsection (2) and paragraph (d) of subsection (3) of section 409.9082, Florida Statutes, are amended to read:

409.9082 Quality assessment on nursing home facility providers; exemptions; purpose; federal approval required; remedies.—

(2) Effective April 1, 2009, a quality assessment ~~there~~ is imposed upon each nursing home facility ~~a quality assessment~~. The aggregated amount of

assessments for all nursing home facilities in a given year shall be an amount not exceeding the maximum percentage allowed under federal law ~~5.5 percent~~ of the total aggregate net patient service revenue of assessed facilities. The agency shall calculate the quality assessment rate annually on a per-resident-day basis, exclusive of those resident days funded by the Medicare program, as reported by the facilities. The per-resident-day assessment rate must ~~shall~~ be uniform except as prescribed in subsection (3). Each facility shall report monthly to the agency its total number of resident days, exclusive of Medicare Part A resident days, and ~~shall~~ remit an amount equal to the assessment rate times the reported number of days. The agency shall collect, and each facility shall pay, the quality assessment each month. The agency shall collect the assessment from nursing home facility providers by ~~no later than~~ the 15th day of the next succeeding calendar month. The agency shall notify providers of the quality assessment and provide a standardized form to complete and submit with payments. The collection of the nursing home facility quality assessment shall commence no sooner than 5 days after the agency's initial payment of the Medicaid rates containing the elements prescribed in subsection (4). Nursing home facilities may not create a separate line-item charge for the purpose of passing ~~through~~ the assessment through to residents.

(3)

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

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

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

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

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

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

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

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

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

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

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

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

$$TAP = TAE \times TA$$

Where:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

409.9113 Disproportionate share program for teaching hospitals.—In addition to the payments made under ss. 409.911 and 409.9112, the agency shall make disproportionate share payments to ~~statutorily defined~~ teaching hospitals, as defined in s. 408.07, for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments must conform to federal requirements and distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the 2011-2012 ~~2010-2011~~ state fiscal year, the agency shall distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals, as defined in s. 395.805, pursuant to this section ~~under the teaching hospital disproportionate share program~~. The funds provided for statutorily defined teaching hospitals shall be distributed ~~in the same proportion as the state fiscal year 2003-2004 teaching hospital disproportionate share funds were distributed or~~ as ~~otherwise~~ provided in the General Appropriations Act. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

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

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

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

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

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

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

(c) A service index that comprises three components:

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

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the agency ~~for Health Care Administration~~ to the volume of each service, expressed in terms of the

standard units of measure reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all ~~state~~ statutory teaching hospitals.

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

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

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

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

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

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

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

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

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

TAE = HDSP/THDSP

Where:

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

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

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

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

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

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

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

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

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

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

be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.

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

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

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

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

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

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

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

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

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

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of

long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c) or paragraph (d), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The Secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing The behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations and capitated provider service networks, to be expended for the provision of behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this

section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

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

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

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization, a provider service network authorized under paragraph (d), or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations are eligible to compete. Managed care plans contracting with the agency under subsection (3) or paragraph (d), shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts must be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of

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

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

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

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

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

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

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

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to

accept or decline a contract to participate in any provider network for prepaid behavioral health services.

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

(16)

(b) The responsibility of the agency under this subsection includes ~~shall include~~ the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.

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

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

3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries inappropriately using their benefits, and other steps that ~~will~~ eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

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

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

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

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

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the ~~preferred drug~~ list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may ~~is authorized to~~ seek any federal waivers necessary to implement these

cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer ~~implement~~ this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

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

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

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

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

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

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

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

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

8. The agency ~~for Health Care Administration~~ shall expand home delivery of pharmacy products. The agency may amend the state plan and issue a procurement, as necessary, in order to implement this program. The procurements must include agreements with a pharmacy or pharmacies located in the state to provide mail order delivery services at no cost to the recipients who elect to receive home delivery of pharmacy products. The procurement must focus on serving recipients with chronic diseases for which pharmacy expenditures represent a significant portion of Medicaid pharmacy expenditures or which impact a significant portion of the Medicaid population. ~~To assist Medicaid patients in securing their prescriptions and~~

~~reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract.~~ The agency may seek and implement any federal waivers necessary to implement this subparagraph.

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

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

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

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

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

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

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

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

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

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

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

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

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

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

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

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

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

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

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

(2)

(m) If the Medicaid recipient is diagnosed with HIV/AIDS and resides in Broward, Miami-Dade, or Palm Beach counties, the agency shall assign the recipient to a managed care plan that is a health maintenance organization authorized under Chapter 641, under contract with the agency on July 1, 2011, and which offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS.

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

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

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

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

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

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

Section 17. Notwithstanding s. 430.707, Florida Statutes, and subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly, the Agency for Health Care Administration shall contract with one private health care organization, the sole member of which is a private, not-for-profit corporation that owns and manages health care organizations which provide comprehensive long-term care services, including nursing home, assisted living, independent housing, home care, adult day care, and care management, with a board-certified, trained geriatrician as the medical director. This organization shall provide these services to frail and elderly persons who reside in Palm Beach County. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and subject to an appropriation, shall approve up to 150 initial enrollees in the Program of All-inclusive Care for the Elderly established by this organization to serve elderly persons who reside in Palm Beach County.

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

Approved by the Governor May 26, 2011.

Filed in Office Secretary of State May 26, 2011.