

1 A bill to be entitled
2 An act relating to the Agency for Health Care
3 Administration; amending s. 409.904, F.S.;
4 providing for the agency to pay for health
5 insurance premiums for certain
6 Medicaid-eligible persons; providing for the
7 agency to pay for specified cancer treatment;
8 providing Medicaid eligibility for certain
9 disabled persons under a Medicaid buy-in
10 program, subject to specific federal
11 authorization; directing the Agency for Health
12 Care Administration to seek a federal grant,
13 demonstration project, or waiver for
14 establishment of such buy-in program, subject
15 to a specific appropriation; amending s.
16 409.905, F.S.; prescribing conditions upon
17 which an adjustment in a hospital's inpatient
18 per diem rate may be based; prescribing
19 additional limitations that may be placed on
20 hospital inpatient services under Medicaid;
21 amending s. 409.906, F.S.; providing for
22 reimbursement and use-management reforms with
23 respect to community mental health services;
24 revising standards for payable intermediate
25 care services; authorizing the agency to pay
26 for assistive-care services; amending s.
27 409.908, F.S.; providing for a temporary rate
28 reduction; revising standards, guidelines, and
29 limitations relating to reimbursement of
30 Medicaid providers; amending s. 409.911, F.S.;
31 updating data requirements and share rates for

1 disproportionate share distributions; amending
2 s. 409.9116, F.S.; modifying the formula for
3 disproportionate share/financial assistance
4 distribution to rural hospitals; amending s.
5 409.91195, F.S.; requiring the Medicaid
6 Pharmaceutical and Therapeutics Committee to
7 recommend a preferred drug formulary; revising
8 the membership of the Medicaid Pharmaceutical
9 and Therapeutics Committee; providing for
10 committee responsibilities; requiring the
11 agency to publish the preferred drug formulary;
12 providing for a hearing process; amending s.
13 409.912, F.S.; authorizing the agency to
14 establish requirements for prior authorization
15 for certain populations, drug classes, or
16 particular drugs; specifying conditions under
17 which the agency may enter certain contracts
18 with exclusive provider organizations; revising
19 components of the agency's spending-control
20 program; prescribing additional services that
21 the agency may provide through competitive
22 bidding; authorizing the agency to establish,
23 and make exceptions to, a restricted-drug
24 formulary; directing the agency to establish a
25 demonstration project in Miami-Dade County to
26 provide minority health care; amending s.
27 409.9122, F.S.; providing for disproportionate
28 assignment of certain Medicaid-eligible
29 children to children's clinic networks;
30 providing for assignment of certain Medicaid
31 recipients to managed-care plans; amending s.

1 409.915, F.S.; exempting counties from
2 contributing toward the increased cost of
3 hospital inpatient services due to elimination
4 of Medicaid ceilings on certain types of
5 hospitals and for special Medicaid
6 reimbursement to hospitals; revising the level
7 of county participation; providing for
8 distribution of funds under the
9 disproportionate share program for specified
10 hospitals for the 2001 federal fiscal year;
11 providing for the distribution of County Health
12 Department Trust Funds; requiring the
13 certificate-of-need workgroup to review and
14 make recommendations regarding specified
15 regulations; providing for a temporary rate
16 reduction; providing for an exemption from
17 review for transfer of certain beds and
18 services to a satellite facility; providing for
19 future repeal; providing an appropriation;
20 amending ss. 240.4075, 240.4076, F.S.;
21 including nursing homes, family practice
22 teaching hospitals and specialty children's
23 hospitals as facilities eligible under the
24 program; exempting such hospitals from the
25 fund-matching requirements of the program;
26 transferring the program from the Board of
27 Regents to the Department of Health; providing
28 effective dates.

29
30 Be It Enacted by the Legislature of the State of Florida:
31

1 Section 1. Subsections (9), (10), and (11) are added
2 to section 409.904, Florida Statutes, to read:

3 409.904 Optional payments for eligible persons.--The
4 agency may make payments for medical assistance and related
5 services on behalf of the following persons who are determined
6 to be eligible subject to the income, assets, and categorical
7 eligibility tests set forth in federal and state law. Payment
8 on behalf of these Medicaid eligible persons is subject to the
9 availability of moneys and any limitations established by the
10 General Appropriations Act or chapter 216.

11 (9) A Medicaid-eligible individual for the
12 individual's health insurance premiums, if the agency
13 determines that such payments are cost-effective.

14 (10) Eligible women with incomes below 200 percent of
15 the federal poverty level and under age 65, for cancer
16 treatment pursuant to the federal Breast and Cervical Cancer
17 Prevention and Treatment Act of 2000, screened through the
18 National Breast and Cervical Cancer Early Detection program.

19 (11) Subject to specific federal authorization, a
20 person who, but for earnings in excess of the limit
21 established under s. 1905(q)(2)(B) of the Social Security Act,
22 would be considered for receiving supplemental security
23 income, who is at least 16 but less than 65 years of age, and
24 whose assets, resources, and earned or unearned income, or
25 both, do not exceed 250 percent of the most current federal
26 poverty level. Such persons may be eligible for Medicaid
27 services as part of a Medicaid buy-in established under s.
28 409.914(2) specifically designed to accommodate those persons
29 made eligible for such a buy-in by Title II of Pub. L. No.
30 106-170. Such buy-in shall include income-related premiums and
31 cost sharing.

1 Section 2. Subject to a specific appropriation, the
2 Agency for Health Care Administration is directed to seek a
3 federal grant, demonstration project, or waiver, as may be
4 authorized by the United States Department of Health and Human
5 Services, for purposes of establishing a Medicaid buy-in
6 program or other programs to assist individuals with
7 disabilities in gaining employment. The services to be
8 provided are those required to enable such individuals to gain
9 or keep employment. The grant, demonstration project, or
10 waiver shall be submitted to the Secretary of Health and Human
11 Services at such time, in such manner, and containing such
12 information as the secretary shall require, as authorized
13 under Title II of Pub. L. No. 106-170, the "Ticket to Work and
14 Work Incentives Act of 1999."

15 Section 3. Subsection (5) of section 409.905, Florida
16 Statutes, is amended to read:

17 409.905 Mandatory Medicaid services.--The agency may
18 make payments for the following services, which are required
19 of the state by Title XIX of the Social Security Act,
20 furnished by Medicaid providers to recipients who are
21 determined to be eligible on the dates on which the services
22 were provided. Any service under this section shall be
23 provided only when medically necessary and in accordance with
24 state and federal law. Nothing in this section shall be
25 construed to prevent or limit the agency from adjusting fees,
26 reimbursement rates, lengths of stay, number of visits, number
27 of services, or any other adjustments necessary to comply with
28 the availability of moneys and any limitations or directions
29 provided for in the General Appropriations Act or chapter 216.

30 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay
31 for all covered services provided for the medical care and

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

7 (a) The agency is authorized to implement
8 reimbursement and utilization management reforms in order to
9 comply with any limitations or directions in the General
10 Appropriations Act, which may include, but are not limited to:
11 prior authorization for inpatient psychiatric days; prior
12 authorization for nonemergency hospital inpatient admissions
13 for individuals 21 years of age and older; authorization of
14 emergency and urgent-care admissions within 24 hours after
15 admission; enhanced utilization and concurrent review programs
16 for highly utilized services; reduction or elimination of
17 covered days of service; adjusting reimbursement ceilings for
18 variable costs; adjusting reimbursement ceilings for fixed and
19 property costs; and implementing target rates of increase. The
20 agency may limit prior authorization for hospital inpatient
21 services to selected diagnosis-related groups, based on an
22 analysis of the cost and potential for unnecessary
23 hospitalizations represented by certain diagnoses. Admissions
24 for normal delivery and newborns are exempt from requirements
25 for prior authorization. In implementing the provisions of
26 this section related to prior authorization, the agency shall
27 ensure that the process for authorization is accessible 24
28 hours per day, 7 days per week and authorization is
29 automatically granted when not denied within 4 hours after the
30 request. Authorization procedures must include steps for
31 review of denials. Upon implementing the prior authorization

1 program for hospital inpatient services, the agency shall
2 discontinue its hospital retrospective review program.

3 (b) A licensed hospital maintained primarily for the
4 care and treatment of patients having mental disorders or
5 mental diseases is not eligible to participate in the hospital
6 inpatient portion of the Medicaid program except as provided
7 in federal law. However, the department shall apply for a
8 waiver, within 9 months after June 5, 1991, designed to
9 provide hospitalization services for mental health reasons to
10 children and adults in the most cost-effective and lowest cost
11 setting possible. Such waiver shall include a request for the
12 opportunity to pay for care in hospitals known under federal
13 law as "institutions for mental disease" or "IMD's." The
14 waiver proposal shall propose no additional aggregate cost to
15 the state or Federal Government, and shall be conducted in
16 Hillsborough County, Highlands County, Hardee County, Manatee
17 County, and Polk County. The waiver proposal may incorporate
18 competitive bidding for hospital services, comprehensive
19 brokering, prepaid capitated arrangements, or other mechanisms
20 deemed by the department to show promise in reducing the cost
21 of acute care and increasing the effectiveness of preventive
22 care. When developing the waiver proposal, the department
23 shall take into account price, quality, accessibility,
24 linkages of the hospital to community services and family
25 support programs, plans of the hospital to ensure the earliest
26 discharge possible, and the comprehensiveness of the mental
27 health and other health care services offered by participating
28 providers.

29 (c) Agency for Health Care Administration shall adjust
30 a hospital's current inpatient per diem rate to reflect the
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1 cost of serving the Medicaid population at that institution
2 if:

3 1. The hospital experiences an increase in Medicaid
4 caseload by more than 25 percent in any year, primarily
5 resulting from the closure of a hospital in the same service
6 area occurring after July 1, 1995; or

7 2. The hospital's Medicaid per diem rate is at least
8 25 percent below the Medicaid per patient cost for that year.

9
10 No later than November 1, 2001 ~~2000~~, the agency must provide
11 estimated costs for any adjustment in a hospital inpatient per
12 diem pursuant to this paragraph to the Executive Office of the
13 Governor, the House of Representatives General Appropriations
14 Committee, and the Senate Appropriations ~~Budget~~ Committee.
15 Before the agency implements a change in a hospital's
16 inpatient per diem rate pursuant to this paragraph, the
17 Legislature must have specifically appropriated sufficient
18 funds in the ~~2001-2002~~ General Appropriations Act to support
19 the increase in cost as estimated by the agency. ~~This~~
20 ~~paragraph is repealed on July 1, 2001.~~

21 Section 4. Subsection (8) of section 409.906, Florida
22 Statutes, is amended, and subsection (25) is added to that
23 section, to read:

24 409.906 Optional Medicaid services.--Subject to
25 specific appropriations, the agency may make payments for
26 services which are optional to the state under Title XIX of
27 the Social Security Act and are furnished by Medicaid
28 providers to recipients who are determined to be eligible on
29 the dates on which the services were provided. Any optional
30 service that is provided shall be provided only when medically
31 necessary and in accordance with state and federal law.

1 Nothing in this section shall be construed to prevent or limit
2 the agency from adjusting fees, reimbursement rates, lengths
3 of stay, number of visits, or number of services, or making
4 any other adjustments necessary to comply with the
5 availability of moneys and any limitations or directions
6 provided for in the General Appropriations Act or chapter 216.
7 If necessary to safeguard the state's systems of providing
8 services to elderly and disabled persons and subject to the
9 notice and review provisions of s. 216.177, the Governor may
10 direct the Agency for Health Care Administration to amend the
11 Medicaid state plan to delete the optional Medicaid service
12 known as "Intermediate Care Facilities for the Developmentally
13 Disabled." Optional services may include:

14 (8) COMMUNITY MENTAL HEALTH SERVICES.--

15 (a) The agency may pay for rehabilitative services
16 provided to a recipient by a mental health or substance abuse
17 provider ~~licensed by the agency~~ and under contract with the
18 agency or the Department of Children and Family Services to
19 provide such services. Those services which are psychiatric
20 in nature shall be rendered or recommended by a psychiatrist,
21 and those services which are medical in nature shall be
22 rendered or recommended by a physician or psychiatrist. The
23 agency must develop a provider enrollment process for
24 community mental health providers which bases provider
25 enrollment on an assessment of service need. The provider
26 enrollment process shall be designed to control costs, prevent
27 fraud and abuse, consider provider expertise and capacity, and
28 assess provider success in managing utilization of care and
29 measuring treatment outcomes. Providers will be selected
30 through a competitive procurement or selective contracting
31 process. In addition to other community mental health

1 providers, the agency shall consider for enrollment mental
2 health programs licensed under chapter 395 and group practices
3 licensed under chapter 458, chapter 459, chapter 490, or
4 chapter 491. The agency is also authorized to continue
5 operation of its behavioral health utilization management
6 program and may develop new services if these actions are
7 necessary to ensure savings from the implementation of the
8 utilization management system. The agency shall coordinate the
9 implementation of this enrollment process with the Department
10 of Children and Family Services and the Department of Juvenile
11 Justice. The agency is authorized to utilize diagnostic
12 criteria in setting reimbursement rates, to preauthorize
13 certain high-cost or highly utilized services, to limit or
14 eliminate coverage for certain services, or to make any other
15 adjustments necessary to comply with any limitations or
16 directions provided for in the General Appropriations Act.

17 (b) The agency is authorized to implement
18 reimbursement and use management reforms in order to comply
19 with any limitations or directions in the General
20 Appropriations Act, which may include, but are not limited to:
21 prior authorization of treatment and service plans; prior
22 authorization of services; enhanced use review programs for
23 highly used services; and limits on services for those
24 determined to be abusing their benefit coverages.

25 (25) ASSISTIVE-CARE SERVICES.--The agency may pay for
26 assistive-care services provided to recipients with functional
27 or cognitive impairments residing in assisted living
28 facilities, adult family-care homes, or residential treatment
29 facilities. These services may include health support,
30 assistance with the activities of daily living and the

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1 instrumental acts of daily living, assistance with medication
2 administration, and arrangements for health care.

3 Section 5. Paragraph (a) of subsection (1), paragraph
4 (b) of subsection (2), and subsections (4), (9), (11), (13),
5 (14), and (18) of section 409.908, Florida Statutes, are
6 amended, and subsection (22) is added to that section, to
7 read:

8 409.908 Reimbursement of Medicaid providers.--Subject
9 to specific appropriations, the agency shall reimburse
10 Medicaid providers, in accordance with state and federal law,
11 according to methodologies set forth in the rules of the
12 agency and in policy manuals and handbooks incorporated by
13 reference therein. These methodologies may include fee
14 schedules, reimbursement methods based on cost reporting,
15 negotiated fees, competitive bidding pursuant to s. 287.057,
16 and other mechanisms the agency considers efficient and
17 effective for purchasing services or goods on behalf of
18 recipients. Payment for Medicaid compensable services made on
19 behalf of Medicaid eligible persons is subject to the
20 availability of moneys and any limitations or directions
21 provided for in the General Appropriations Act or chapter 216.
22 Further, nothing in this section shall be construed to prevent
23 or limit the agency from adjusting fees, reimbursement rates,
24 lengths of stay, number of visits, or number of services, or
25 making any other adjustments necessary to comply with the
26 availability of moneys and any limitations or directions
27 provided for in the General Appropriations Act, provided the
28 adjustment is consistent with legislative intent.

29 (1) Reimbursement to hospitals licensed under part I
30 of chapter 395 must be made prospectively or on the basis of
31 negotiation.

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

3 1. The raising of rate reimbursement caps, excluding
4 rural hospitals.

5 2. Recognition of the costs of graduate medical
6 education.

7 3. Other methodologies recognized in the General
8 Appropriations Act.

9 4. Hospital inpatient rates shall be reduced by 6
10 percent effective July 1, 2001 and restored effective April 1,
11 2002.

12
13 During the years funds are transferred from the Department of
14 Health Board of Regents, any reimbursement supported by such
15 funds shall be subject to certification by the Department of
16 Health Board of Regents that the hospital has complied with s.
17 381.0403. The agency is authorized to receive funds from state
18 entities, including, but not limited to, the Department of
19 Health Board of Regents, local governments, and other local
20 political subdivisions, for the purpose of making special
21 exception payments, including federal matching funds, through
22 the Medicaid inpatient reimbursement methodologies. Funds
23 received from state entities or local governments for this
24 purpose shall be separately accounted for and shall not be
25 commingled with other state or local funds in any manner. The
26 agency may certify all local governmental funds used as state
27 match under Title XIX of the Social Security Act, to the
28 extent that the identified local health care provider that is
29 otherwise entitled to and is contracted to receive such local
30 funds is the benefactor under the state's Medicaid program as
31 determined under the General Appropriations Act and pursuant

1 to an agreement between the Agency for Health Care
2 Administration and the local governmental entity. The local
3 governmental entity shall use a certification form prescribed
4 by the agency. At a minimum, the certification form shall
5 identify the amount being certified and describe the
6 relationship between the certifying local governmental entity
7 and the local health care provider. The agency shall prepare
8 an annual statement of impact which documents the specific
9 activities undertaken during the previous fiscal year pursuant
10 to this paragraph, to be submitted to the Legislature no later
11 than January 1, annually.~~Notwithstanding this section and s.~~
12 ~~409.915, counties are exempt from contributing toward the cost~~
13 ~~of the special exception reimbursement for hospitals serving a~~
14 ~~disproportionate share of low-income persons and providing~~
15 ~~graduate medical education.~~

16 (2)

17 (b) Subject to any limitations or directions provided
18 for in the General Appropriations Act, the agency shall
19 establish and implement a Florida Title XIX Long-Term Care
20 Reimbursement Plan (Medicaid) for nursing home care in order
21 to provide care and services in conformance with the
22 applicable state and federal laws, rules, regulations, and
23 quality and safety standards and to ensure that individuals
24 eligible for medical assistance have reasonable geographic
25 access to such care. The agency shall not provide for any
26 increases for patient care or operating components of
27 reimbursement rates to nursing homes associated with changes
28 in ownership or licensed operators filed on or after October
29 1, 2001.Under the plan, interim rate adjustments shall not be
30 granted to reflect increases in the cost of general or
31 professional liability insurance for nursing homes unless the

1 following criteria are met: have at least a 65 percent
2 Medicaid utilization in the most recent cost report submitted
3 to the agency, and the increase in general or professional
4 liability costs to the facility for the most recent policy
5 period affects the total Medicaid per diem by at least 5
6 percent. This rate adjustment shall not result in the per diem
7 exceeding the class ceiling. ~~This provision shall apply only
8 to fiscal year 2000-2001 and shall be implemented to the
9 extent existing appropriations are available. The agency shall
10 report to the Governor, the Speaker of the House of
11 Representatives, and the President of the Senate by December
12 31, 2000, on the cost of liability insurance for Florida
13 nursing homes for fiscal years 1999 and 2000 and the extent to
14 which these costs are not being compensated by the Medicaid
15 program. Medicaid-participating nursing homes shall be
16 required to report to the agency information necessary to
17 compile this report. Effective no earlier than the
18 rate-setting period beginning April 1, 1999,~~The agency shall
19 establish a case-mix reimbursement methodology for the rate of
20 payment for long-term care services for nursing home
21 residents. The agency shall compute a per diem rate for
22 Medicaid residents, adjusted for case mix, which is based on a
23 resident classification system that accounts for the relative
24 resource utilization by different types of residents and which
25 is based on level-of-care data and other appropriate data. The
26 case-mix methodology developed by the agency shall take into
27 account the medical, behavioral, and cognitive deficits of
28 residents. In developing the reimbursement methodology, the
29 agency shall evaluate and modify other aspects of the
30 reimbursement plan as necessary to improve the overall
31 effectiveness of the plan with respect to the costs of patient

1 care, operating costs, and property costs. In the event
2 adequate data are not available, the agency is authorized to
3 adjust the patient's care component or the per diem rate to
4 more adequately cover the cost of services provided in the
5 patient's care component. The agency shall work with the
6 Department of Elderly Affairs, the Florida Health Care
7 Association, and the Florida Association of Homes for the
8 Aging in developing the methodology. It is the intent of the
9 Legislature that the reimbursement plan achieve the goal of
10 providing access to health care for nursing home residents who
11 require large amounts of care while encouraging diversion
12 services as an alternative to nursing home care for residents
13 who can be served within the community. The agency shall base
14 the establishment of any maximum rate of payment, whether
15 overall or component, on the available moneys as provided for
16 in the General Appropriations Act. The agency may base the
17 maximum rate of payment on the results of scientifically valid
18 analysis and conclusions derived from objective statistical
19 data pertinent to the particular maximum rate of payment.

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

1 calculations. Effective July 1, 2001, the cost of exempting
2 statutory teaching hospitals, specialty hospitals, and
3 community hospital education program hospitals from
4 reimbursement ceilings and the cost of special Medicaid
5 payments shall not be included in premiums paid to health
6 maintenance organizations or prepaid health care plans. Each
7 rate semester, the agency shall calculate and publish a
8 Medicaid hospital rate schedule that does not reflect either
9 special Medicaid payments or the elimination of rate
10 reimbursement ceilings, to be used by hospitals and Medicaid
11 health maintenance organizations, in order to determine the
12 Medicaid rate referred to in ss. 409.912(16), 409.9128(5), and
13 641.513(6).

14 (9) A provider of home health care services or of
15 medical supplies and appliances shall be reimbursed on the
16 basis of competitive bidding or for the lesser of the amount
17 billed by the provider or the agency's established maximum
18 allowable amount, except that, in the case of the rental of
19 durable medical equipment, the total rental payments may not
20 exceed the purchase price of the equipment over its expected
21 useful life or the agency's established maximum allowable
22 amount, whichever amount is less.

23 (11) A provider of independent laboratory services
24 shall be reimbursed on the basis of competitive bidding or for
25 the least of the amount billed by the provider, the provider's
26 usual and customary charge, or the Medicaid maximum allowable
27 fee established by the agency.

28 (13) Medicare premiums for persons eligible for both
29 Medicare and Medicaid coverage shall be paid at the rates
30 established by Title XVIII of the Social Security Act. For
31 Medicare services rendered to Medicaid-eligible persons,

1 Medicaid shall pay Medicare deductibles and coinsurance as
2 follows:

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

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

9 (c) Medicaid will pay no portion of Medicare
10 deductibles and coinsurance when payment that Medicare has
11 made for the service equals or exceeds what Medicaid would
12 have paid if it had been the sole payor. The combined payment
13 of Medicare and Medicaid shall not exceed the amount Medicaid
14 would have paid had it been the sole payor. The Legislature
15 finds that there has been confusion regarding the
16 reimbursement for services rendered to dually eligible
17 Medicare beneficiaries. Accordingly, the Legislature clarifies
18 that it has always been the intent of the Legislature before
19 and after 1991 that, in reimbursing in accordance with fees
20 established by Title XVIII for premiums, deductibles, and
21 coinsurance for Medicare services rendered by physicians to
22 Medicaid eligible persons, physicians be reimbursed at the
23 lesser of the amount billed by the physician or the Medicaid
24 maximum allowable fee established by the Agency for Health
25 Care Administration, as is permitted by federal law. It has
26 never been the intent of the Legislature with regard to such
27 services rendered by physicians that Medicaid be required to
28 provide any payment for deductibles, coinsurance, or
29 copayments for Medicare cost sharing, or any expenses incurred
30 relating thereto, in excess of the payment amount provided for
31 under the State Medicaid plan for such service. This payment

1 methodology is applicable even in those situations in which
2 the payment for Medicare cost sharing for a qualified Medicare
3 beneficiary with respect to an item or service is reduced or
4 eliminated. This expression of the Legislature is in
5 clarification of existing law and shall apply to payment for,
6 and with respect to provider agreements with respect to, items
7 or services furnished on or after the effective date of this
8 act. This paragraph applies to payment by Medicaid for items
9 and services furnished before the effective date of this act
10 if such payment is the subject of a lawsuit that is based on
11 the provisions of this section, and that is pending as of, or
12 is initiated after, the effective date of this act.

13 (d) Notwithstanding ~~The following provisions are~~
14 ~~exceptions to paragraphs (a)-(c):~~

15 1. Medicaid payments for Nursing Home Medicare part A
16 coinsurance shall be the lesser of the Medicare coinsurance
17 amount or the Medicaid nursing home per diem rate.

18 ~~2. Medicaid shall pay all deductibles and coinsurance~~
19 ~~for Nursing Home Medicare part B services.~~

20 2.3. Medicaid shall pay all deductibles and
21 coinsurance for Medicare-eligible recipients receiving
22 freestanding end stage renal dialysis center services.

23 ~~4. Medicaid shall pay all deductibles and coinsurance~~
24 ~~for hospital outpatient Medicare part B services.~~

25 3.5. Medicaid payments for general hospital inpatient
26 services shall be limited to the Medicare deductible per spell
27 of illness. Medicaid shall make no payment toward coinsurance
28 for Medicare general hospital inpatient services.

29 ~~4.6.~~ Medicaid shall pay all deductibles and
30 coinsurance for Medicare emergency transportation services
31 provided by ambulances licensed pursuant to chapter 401.

1 (14) A provider of prescribed drugs shall be
2 reimbursed the least of the amount billed by the provider, the
3 provider's usual and customary charge, or the Medicaid maximum
4 allowable fee established by the agency, plus a dispensing
5 fee. The agency is directed to implement a variable dispensing
6 fee for payments for prescribed medicines while ensuring
7 continued access for Medicaid recipients. The variable
8 dispensing fee may be based upon, but not limited to, either
9 or both the volume of prescriptions dispensed by a specific
10 pharmacy provider and the volume of prescriptions dispensed to
11 an individual recipient. The agency is authorized to limit
12 reimbursement for prescribed medicine in order to comply with
13 any limitations or directions provided for in the General
14 Appropriations Act, which may include implementing a
15 prospective or concurrent utilization review program.

16 (18) Unless otherwise provided for in the General
17 Appropriations Act, a provider of transportation services
18 shall be reimbursed the lesser of the amount billed by the
19 provider or the Medicaid maximum allowable fee established by
20 the agency, except when the agency has entered into a direct
21 contract with the provider, or with a community transportation
22 coordinator, for the provision of an all-inclusive service, or
23 when services are provided pursuant to an agreement negotiated
24 between the agency and the provider. The agency, as provided
25 for in s. 427.0135, shall purchase transportation services
26 through the community coordinated transportation system, if
27 available, unless the agency determines a more cost-effective
28 method for Medicaid clients. Nothing in this subsection shall
29 be construed to limit or preclude the agency from contracting
30 for services using a prepaid capitation rate or from
31 establishing maximum fee schedules, individualized

1 reimbursement policies by provider type, negotiated fees,
2 prior authorization, competitive bidding, increased use of
3 mass transit, or any other mechanism that the agency considers
4 efficient and effective for the purchase of services on behalf
5 of Medicaid clients, including implementing a transportation
6 eligibility process. The agency shall not be required to
7 contract with any community transportation coordinator or
8 transportation operator that has been determined by the
9 agency, the Department of Legal Affairs Medicaid Fraud Control
10 Unit, or any other state or federal agency to have engaged in
11 any abusive or fraudulent billing activities. The agency is
12 authorized to competitively procure transportation services or
13 make other changes necessary to secure approval of federal
14 waivers needed to permit federal financing of Medicaid
15 transportation services at the service matching rate rather
16 than the administrative matching rate.

17 (22) The agency may request and implement Medicaid
18 waivers from the federal Health Care Financing Administration
19 to advance and treat a portion of the Medicaid nursing home
20 per diem as capital for creating and operating a
21 risk-retention group for self-insurance purposes, consistent
22 with federal and state laws and rules.

23 Section 6. Paragraph (c) of subsection (1), paragraph
24 (b) of subsection (3), and subsection (7) of section 409.911,
25 Florida Statutes, are amended to read:

26 409.911 Disproportionate share program.--Subject to
27 specific allocations established within the General
28 Appropriations Act and any limitations established pursuant to
29 chapter 216, the agency shall distribute, pursuant to this
30 section, moneys to hospitals providing a disproportionate
31 share of Medicaid or charity care services by making quarterly

1 Medicaid payments as required. Notwithstanding the provisions
2 of s. 409.915, counties are exempt from contributing toward
3 the cost of this special reimbursement for hospitals serving a
4 disproportionate share of low-income patients.

5 (1) Definitions.--As used in this section and s.
6 409.9112:

7 (c) "Base Medicaid per diem" means the hospital's
8 Medicaid per diem rate initially established by the Agency for
9 Health Care Administration on January 1, 1999 ~~prior to the~~
10 ~~beginning of each state fiscal year~~. The base Medicaid per
11 diem rate shall not include any additional per diem increases
12 received as a result of the disproportionate share
13 distribution.

14 (3) In computing the disproportionate share rate:

15 (b) The agency shall use 1994 ~~the most recent calendar~~
16 ~~year audited financial data available at the beginning of each~~
17 ~~state fiscal year~~ for the calculation of disproportionate
18 share payments under this section.

19 ~~For fiscal year 1991-1992 and all years other than~~
20 ~~1992-1993,~~The following criteria shall be used in determining
21 the disproportionate share percentage:

22 (a) If the disproportionate share rate is less than 10
23 percent, the disproportionate share percentage is zero and
24 there is no additional payment.

25 (b) If the disproportionate share rate is greater than
26 or equal to 10 percent, but less than 20 percent, then the
27 disproportionate share percentage is 1.8478498 ~~2.1544347~~.

28 (c) If the disproportionate share rate is greater than
29 or equal to 20 percent, but less than 30 percent, then the
30 disproportionate share percentage is 3.4145488 ~~4.6415888766~~.

31

1 (d) If the disproportionate share rate is greater than
2 or equal to 30 percent, but less than 40 percent, then the
3 disproportionate share percentage is 6.3095734 ~~10.0000001388~~.

4 (e) If the disproportionate share rate is greater than
5 or equal to 40 percent, but less than 50 percent, then the
6 disproportionate share percentage is 11.6591440 ~~21.544347299~~.

7 (f) If the disproportionate share rate is greater than
8 or equal to 50 percent, but less than 60 percent, then the
9 disproportionate share percentage is 73.5642254 ~~46.41588941~~.

10 (g) If the disproportionate share rate is greater than
11 or equal to 60 percent but less than 72.5 percent, then the
12 disproportionate share percentage is 135.9356391 ~~100~~.

13 (h) If the disproportionate share rate is greater than
14 or equal to 72.5 percent, then the disproportionate share
15 percentage is 170.

16 Section 7. Subsection (2) of section 409.9116, Florida
17 Statutes, is amended to read:

18 409.9116 Disproportionate share/financial assistance
19 program for rural hospitals.--In addition to the payments made
20 under s. 409.911, the Agency for Health Care Administration
21 shall administer a federally matched disproportionate share
22 program and a state-funded financial assistance program for
23 statutory rural hospitals. The agency shall make
24 disproportionate share payments to statutory rural hospitals
25 that qualify for such payments and financial assistance
26 payments to statutory rural hospitals that do not qualify for
27 disproportionate share payments. The disproportionate share
28 program payments shall be limited by and conform with federal
29 requirements. Funds shall be distributed quarterly in each
30 fiscal year for which an appropriation is made.
31 Notwithstanding the provisions of s. 409.915, counties are

1 exempt from contributing toward the cost of this special
2 reimbursement for hospitals serving a disproportionate share
3 of low-income patients.

4 (2) The agency shall use the following formula for
5 distribution of funds for the disproportionate share/financial
6 assistance program for rural hospitals.

7 (a) The agency shall first determine a preliminary
8 payment amount for each rural hospital by allocating all
9 available state funds using the following formula:

$$\text{PDAER} = (\text{TAERH} \times \text{TARH}) / \text{STAERH}$$

10
11
12
13 Where:

14 PDAER = preliminary distribution amount for each rural
15 hospital.

16 TAERH = total amount earned by each rural hospital.

17 TARH = total amount appropriated or distributed under
18 this section.

19 STAERH = sum of total amount earned by each rural
20 hospital.

21 (b) Federal matching funds for the disproportionate
22 share program shall then be calculated for those hospitals
23 that qualify for disproportionate share in paragraph (a).

24 (c) The state-funds-only payment amount shall then be
25 calculated for each hospital using the formula:

$$\text{SFOER} = \text{Maximum value of (1) SFOL} - \text{PDAER or (2) 0}$$

26
27
28
29 Where:

30 SFOER = state-funds-only payment amount for each rural
31 hospital.

1 SFOL = state-funds-only payment level, which is set at
2 4 percent of TARH.

3
4 In calculating the SFOER, PDAER includes federal matching
5 funds from paragraph (b).

6 (d) The adjusted total amount allocated to the rural
7 disproportionate share program shall then be calculated using
8 the following formula:

$$\text{ATARH} = (\text{TARH} - \text{SSFOER})$$

9
10
11
12 Where:

13 ATARH = adjusted total amount appropriated or
14 distributed under this section.

15 SSFOER = sum of the state-funds-only payment amount
16 calculated under paragraph (c) for all rural hospitals.

17 (e) The distribution of the adjusted total amount of
18 rural disproportionate share hospital funds shall then be
19 calculated using the following formula:

$$\text{DAERH} = [(\text{TAERH} \times \text{ATARH}) / \text{STAERH}]$$

20
21
22
23 Where:

24 DAERH = distribution amount for each rural hospital.

25 (f) Federal matching funds for the disproportionate
26 share program shall then be calculated for those hospitals
27 that qualify for disproportionate share in paragraph (e).

28 (g) State-funds-only payment amounts calculated under
29 paragraph (c) and corresponding federal matching funds are
30 then added to the results of paragraph (f) to determine the
31 total distribution amount for each rural hospital.

1 ~~In determining the payment amount for each rural~~
2 ~~hospital under this section, the agency shall first allocate~~
3 ~~all available state funds by the following formula:~~

$$4 \qquad \qquad \qquad 5 \qquad \qquad \qquad \text{DAER} = (\text{TAERH} \times \text{TARH}) / \text{STAERH}$$

6
7 ~~Where:~~

8 ~~DAER = distribution amount for each rural hospital.~~

9 ~~STAERH = sum of total amount earned by each rural~~
10 ~~hospital.~~

11 ~~TAERH = total amount earned by each rural hospital.~~

12 ~~TARH = total amount appropriated or distributed under~~
13 ~~this section.~~

14
15 ~~Federal matching funds for the disproportionate share program~~
16 ~~shall then be calculated for those hospitals that qualify for~~
17 ~~disproportionate share payments under this section.~~

18 Section 8. Section 409.91195, Florida Statutes, is
19 amended to read:

20 409.91195 Medicaid Pharmaceutical and Therapeutics
21 Committee.--There is created a Medicaid Pharmaceutical and
22 Therapeutics Committee within the Agency for Health Care
23 Administration for the purpose of developing a preferred drug
24 formulary pursuant to 42 U.S.C. s. 1396r-8. ~~The committee~~
25 ~~shall develop and implement a voluntary Medicaid preferred~~
26 ~~prescribed drug designation program. The program shall provide~~
27 ~~information to Medicaid providers on medically appropriate and~~
28 ~~cost-efficient prescription drug therapies through the~~
29 ~~development and publication of a voluntary Medicaid preferred~~
30 ~~prescribed drug list.~~

31

1 (1) The Medicaid Pharmaceutical and Therapeutics
2 Committee shall be comprised as specified in 42 U.S.C. s.
3 1396r-8 and consist of eleven members appointed by the
4 Governor. Four members shall be physicians, licensed under
5 chapter 458; one member licensed under chapter 459; five
6 members shall be pharmacists licensed under chapter 465; and
7 one member shall be a consumer representative. ~~of nine members~~
8 ~~appointed as follows: one practicing physician licensed under~~
9 ~~chapter 458, appointed by the Speaker of the House of~~
10 ~~Representatives from a list of recommendations from the~~
11 ~~Florida Medical Association; one practicing physician licensed~~
12 ~~under chapter 459, appointed by the Speaker of the House of~~
13 ~~Representatives from a list of recommendations from the~~
14 ~~Florida Osteopathic Medical Association; one practicing~~
15 ~~physician licensed under chapter 458, appointed by the~~
16 ~~President of the Senate from a list of recommendations from~~
17 ~~the Florida Academy of Family Physicians; one practicing~~
18 ~~podiatric physician licensed under chapter 461, appointed by~~
19 ~~the President of the Senate from a list of recommendations~~
20 ~~from the Florida Podiatric Medical Association; one trauma~~
21 ~~surgeon licensed under chapter 458, appointed by the Speaker~~
22 ~~of the House of Representatives from a list of recommendations~~
23 ~~from the American College of Surgeons; one practicing dentist~~
24 ~~licensed under chapter 466, appointed by the President of the~~
25 ~~Senate from a list of recommendations from the Florida Dental~~
26 ~~Association; one practicing pharmacist licensed under chapter~~
27 ~~465, appointed by the Governor from a list of recommendations~~
28 ~~from the Florida Pharmacy Association; one practicing~~
29 ~~pharmacist licensed under chapter 465, appointed by the~~
30 ~~Governor from a list of recommendations from the Florida~~
31 ~~Society of Health System Pharmacists; and one health care~~

1 ~~professional with expertise in clinical pharmacology appointed~~
2 ~~by the Governor from a list of recommendations from the~~
3 ~~Pharmaceutical Research and Manufacturers Association.~~The
4 members shall be appointed to serve for terms of 2 years from
5 the date of their appointment. Members may be appointed to
6 more than one term. The Agency for Health Care Administration
7 shall serve as staff for the committee and assist them with
8 all ministerial duties. The Governor shall ensure that at
9 least some of the members of the Medicaid Pharmaceutical and
10 Therapeutics Committee represent Medicaid participating
11 physicians and pharmacies serving all segments and diversity
12 of the Medicaid population, and have experience in either
13 developing or practicing under a preferred drug formulary. At
14 least one of the members shall represent the interests of
15 pharmaceutical manufacturers.

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

18 (3) The committee shall meet at least quarterly and
19 may meet at other times at the discretion of the chairperson
20 and members. The committee shall comply with rules adopted by
21 the agency, including notice of any meeting of the committee
22 pursuant to the requirements of the Administrative Procedure
23 Act.

24 (4) Upon recommendation of the Medicaid Pharmaceutical
25 and Therapeutics Committee the agency shall adopt a preferred
26 drug list. To the extent feasible, the committee shall review
27 all drug classes included in the formulary at least every 12
28 months, and may recommend additions to and deletions from the
29 formulary, such that the formulary provides

30 ~~(2) Upon recommendation by the committee, the Agency~~
31 ~~for Health Care Administration shall establish the voluntary~~

1 ~~Medicaid preferred prescribed drug list. Upon further~~
2 ~~recommendation by the committee, the agency shall add to,~~
3 ~~delete from, or modify the list. The committee shall also~~
4 ~~review requests for additions to, deletions from, or~~
5 ~~modifications of the list. The list shall be adopted by the~~
6 ~~committee in consultation with medical specialists, when~~
7 ~~appropriate, using the following criteria: use of the list~~
8 ~~shall be voluntary by providers and the list must provide for~~
9 ~~medically appropriate drug therapies for Medicaid patients~~
10 ~~which achieve cost savings contained in the General~~
11 ~~Appropriations Act.~~

12 (5) Except for mental health-related drugs,
13 anti-retroviral drugs, and drugs for nursing home residents
14 and other institutional residents, reimbursement of drugs not
15 included in the formulary is subject to prior authorization in
16 the Medicaid program.

17 (6)(3) The Agency for Health Care Administration shall
18 publish and disseminate the preferred drug formulary ~~voluntary~~
19 ~~Medicaid preferred prescribed drug list~~ to all Medicaid
20 providers in the state.

21 (7) The committee shall ensure that pharmaceutical
22 manufacturers agreeing to provide a supplemental rebate as
23 outlined in this chapter have an opportunity to present
24 evidence supporting inclusion of a product on the preferred
25 drug list. Upon timely notice, the agency shall ensure that
26 any drug that has been approved or had any of its particular
27 uses approved by the United States Food and Drug
28 Administration under a priority review classification will be
29 reviewed by the Medicaid Pharmaceutical and Therapeutics
30 Committee at the next regularly scheduled meeting. To the
31 extent possible, upon notice by a manufacturer the agency

1 shall also schedule a product review for any new product at
2 the next regularly scheduled Medicaid Pharmaceutical and
3 Therapeutics Committee.

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

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

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

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

27 Section 9. Section 409.912, Florida Statutes, is
28 amended to read:

29 409.912 Cost-effective purchasing of health care.--The
30 agency shall purchase goods and services for Medicaid
31 recipients in the most cost-effective manner consistent with

1 the delivery of quality medical care. The agency shall
2 maximize the use of prepaid per capita and prepaid aggregate
3 fixed-sum basis services when appropriate and other
4 alternative service delivery and reimbursement methodologies,
5 including competitive bidding pursuant to s. 287.057, designed
6 to facilitate the cost-effective purchase of a case-managed
7 continuum of care. The agency shall also require providers to
8 minimize the exposure of recipients to the need for acute
9 inpatient, custodial, and other institutional care and the
10 inappropriate or unnecessary use of high-cost services. The
11 agency may establish prior authorization requirements for
12 certain populations of Medicaid beneficiaries, certain drug
13 classes, or particular drugs to prevent fraud, abuse, overuse,
14 and possible dangerous drug interactions. The Pharmaceutical
15 and Therapeutics Committee shall make recommendations to the
16 agency on drugs for which prior authorization is required. The
17 agency shall inform the Pharmaceutical and Therapeutics
18 Committee of its decisions regarding drugs subject to prior
19 authorization.

20 (1) The agency may enter into agreements with
21 appropriate agents of other state agencies or of any agency of
22 the Federal Government and accept such duties in respect to
23 social welfare or public aid as may be necessary to implement
24 the provisions of Title XIX of the Social Security Act and ss.
25 409.901-409.920.

26 (2) The agency may contract with health maintenance
27 organizations certified pursuant to part I of chapter 641 for
28 the provision of services to recipients.

29 (3) The agency may contract with:

30 (a) An entity that provides no prepaid health care
31 services other than Medicaid services under contract with the

1 agency and which is owned and operated by a county, county
2 health department, or county-owned and operated hospital to
3 provide health care services on a prepaid or fixed-sum basis
4 to recipients, which entity may provide such prepaid services
5 either directly or through arrangements with other providers.
6 Such prepaid health care services entities must be licensed
7 under parts I and III by January 1, 1998, and until then are
8 exempt from the provisions of part I of chapter 641. An entity
9 recognized under this paragraph which demonstrates to the
10 satisfaction of the Department of Insurance that it is backed
11 by the full faith and credit of the county in which it is
12 located may be exempted from s. 641.225.

13 (b) An entity that is providing comprehensive
14 behavioral health care services to certain Medicaid recipients
15 through a capitated, prepaid arrangement pursuant to the
16 federal waiver provided for by s. 409.905(5). Such an entity
17 must be licensed under chapter 624, chapter 636, or chapter
18 641 and must possess the clinical systems and operational
19 competence to manage risk and provide comprehensive behavioral
20 health care to Medicaid recipients. As used in this paragraph,
21 the term "comprehensive behavioral health care services" means
22 covered mental health and substance abuse treatment services
23 that are available to Medicaid recipients. The secretary of
24 the Department of Children and Family Services shall approve
25 provisions of procurements related to children in the
26 department's care or custody prior to enrolling such children
27 in a prepaid behavioral health plan. Any contract awarded
28 under this paragraph must be competitively procured. In
29 developing the behavioral health care prepaid plan procurement
30 document, the agency shall ensure that the procurement
31 document requires the contractor to develop and implement a

1 plan to ensure compliance with s. 394.4574 related to services
2 provided to residents of licensed assisted living facilities
3 that hold a limited mental health license. The agency must
4 ensure that Medicaid recipients have available the choice of
5 at least two managed care plans for their behavioral health
6 care services. The agency may reimburse for
7 substance-abuse-treatment services on a fee-for-service basis
8 until the agency finds that adequate funds are available for
9 capitated, prepaid arrangements.

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

15 2. By December 31, 2001, the agency shall contract
16 with entities providing comprehensive behavioral health care
17 services to Medicaid recipients through capitated, prepaid
18 arrangements in Charlotte, Collier, DeSoto, Escambia, Glades,
19 Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota,
20 and Walton Counties. The agency may contract with entities
21 providing comprehensive behavioral health care services to
22 Medicaid recipients through capitated, prepaid arrangements in
23 Alachua County. The agency may determine if Sarasota County
24 shall be included as a separate catchment area or included in
25 any other agency geographic area.

26 3. Children residing in a Department of Juvenile
27 Justice residential program approved as a Medicaid behavioral
28 health overlay services provider shall not be included in a
29 behavioral health care prepaid health plan pursuant to this
30 paragraph.

31

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

12 5. Traditional community mental health providers under
13 contract with the Department of Children and Family Services
14 pursuant to part IV of chapter 394 and inpatient mental health
15 providers licensed pursuant to chapter 395 must be offered an
16 opportunity to accept or decline a contract to participate in
17 any provider network for prepaid behavioral health services.

18 (c) A federally qualified health center or an entity
19 owned by one or more federally qualified health centers or an
20 entity owned by other migrant and community health centers
21 receiving non-Medicaid financial support from the Federal
22 Government to provide health care services on a prepaid or
23 fixed-sum basis to recipients. Such prepaid health care
24 services entity must be licensed under parts I and III of
25 chapter 641, but shall be prohibited from serving Medicaid
26 recipients on a prepaid basis, until such licensure has been
27 obtained. However, such an entity is exempt from s. 641.225
28 if the entity meets the requirements specified in subsections
29 (14) and (15).

30 (d) No more than four provider service networks for
31 demonstration projects to test Medicaid direct contracting.

1 The demonstration projects may be reimbursed on a
2 fee-for-service or prepaid basis. A provider service network
3 which is reimbursed by the agency on a prepaid basis shall be
4 exempt from parts I and III of chapter 641, but must meet
5 appropriate financial reserve, quality assurance, and patient
6 rights requirements as established by the agency. The agency
7 shall award contracts on a competitive bid basis and shall
8 select bidders based upon price and quality of care. Medicaid
9 recipients assigned to a demonstration project shall be chosen
10 equally from those who would otherwise have been assigned to
11 prepaid plans and MediPass. The agency is authorized to seek
12 federal Medicaid waivers as necessary to implement the
13 provisions of this section. A demonstration project awarded
14 pursuant to this paragraph shall be for 4 ~~2~~ years from the
15 date of implementation.

16 (e) An entity that provides comprehensive behavioral
17 health care services to certain Medicaid recipients through an
18 administrative services organization agreement. Such an entity
19 must possess the clinical systems and operational competence
20 to provide comprehensive health care to Medicaid recipients.
21 As used in this paragraph, the term "comprehensive behavioral
22 health care services" means covered mental health and
23 substance abuse treatment services that are available to
24 Medicaid recipients. Any contract awarded under this paragraph
25 must be competitively procured. The agency must ensure that
26 Medicaid recipients have available the choice of at least two
27 managed care plans for their behavioral health care services.

28 (f) An entity in Pasco County or Pinellas County that
29 provides in-home physician services to Medicaid recipients
30 with degenerative neurological diseases in order to test the
31 cost-effectiveness of enhanced home-based medical care. The

1 entity providing the services shall be reimbursed on a
2 fee-for-service basis at a rate not less than comparable
3 Medicare reimbursement rates. The agency may apply for waivers
4 of federal regulations necessary to implement such program.
5 This paragraph shall be repealed on July 1, 2002.

6 (g) Children's provider networks that provide care
7 coordination and care management for Medicaid-eligible
8 pediatric patients, primary care, authorization of specialty
9 care, and other urgent and emergency care through organized
10 providers designed to service Medicaid eligibles under age 18.
11 The networks shall provide after-hour operations, including
12 evening and weekend hours, to promote, when appropriate, the
13 use of the children's networks rather than hospital emergency
14 departments.

15 (4) The agency may contract with any public or private
16 entity otherwise authorized by this section on a prepaid or
17 fixed-sum basis for the provision of health care services to
18 recipients. An entity may provide prepaid services to
19 recipients, either directly or through arrangements with other
20 entities, if each entity involved in providing services:

21 (a) Is organized primarily for the purpose of
22 providing health care or other services of the type regularly
23 offered to Medicaid recipients;

24 (b) Ensures that services meet the standards set by
25 the agency for quality, appropriateness, and timeliness;

26 (c) Makes provisions satisfactory to the agency for
27 insolvency protection and ensures that neither enrolled
28 Medicaid recipients nor the agency will be liable for the
29 debts of the entity;

30 (d) Submits to the agency, if a private entity, a
31 financial plan that the agency finds to be fiscally sound and

1 that provides for working capital in the form of cash or
2 equivalent liquid assets excluding revenues from Medicaid
3 premium payments equal to at least the first 3 months of
4 operating expenses or \$200,000, whichever is greater;

5 (e) Furnishes evidence satisfactory to the agency of
6 adequate liability insurance coverage or an adequate plan of
7 self-insurance to respond to claims for injuries arising out
8 of the furnishing of health care;

9 (f) Provides, through contract or otherwise, for
10 periodic review of its medical facilities and services, as
11 required by the agency; and

12 (g) Provides organizational, operational, financial,
13 and other information required by the agency.

14 (5) The agency may contract on a prepaid or fixed-sum
15 basis with any health insurer that:

16 (a) Pays for health care services provided to enrolled
17 Medicaid recipients in exchange for a premium payment paid by
18 the agency;

19 (b) Assumes the underwriting risk; and

20 (c) Is organized and licensed under applicable
21 provisions of the Florida Insurance Code and is currently in
22 good standing with the Department of Insurance.

23 (6) The agency may contract on a prepaid or fixed-sum
24 basis with an exclusive provider organization to provide
25 health care services to Medicaid recipients provided that ~~the~~
26 ~~contract does not cost more than a managed care plan contract~~
27 ~~in the same agency region and that the exclusive provider~~
28 organization meets applicable managed care plan requirements
29 in this section, ss. 409.9122, 409.9123, 409.9128, and
30 627.6472, and other applicable provisions of law.

31

1 (7) The Agency for Health Care Administration may
2 provide cost-effective purchasing of chiropractic services on
3 a fee-for-service basis to Medicaid recipients through
4 arrangements with a statewide chiropractic preferred provider
5 organization incorporated in this state as a not-for-profit
6 corporation. The agency shall ensure that the benefit limits
7 and prior authorization requirements in the current Medicaid
8 program shall apply to the services provided by the
9 chiropractic preferred provider organization.

10 (8) The agency shall not contract on a prepaid or
11 fixed-sum basis for Medicaid services with an entity which
12 knows or reasonably should know that any officer, director,
13 agent, managing employee, or owner of stock or beneficial
14 interest in excess of 5 percent common or preferred stock, or
15 the entity itself, has been found guilty of, regardless of
16 adjudication, or entered a plea of nolo contendere, or guilty,
17 to:

18 (a) Fraud;

19 (b) Violation of federal or state antitrust statutes,
20 including those proscribing price fixing between competitors
21 and the allocation of customers among competitors;

22 (c) Commission of a felony involving embezzlement,
23 theft, forgery, income tax evasion, bribery, falsification or
24 destruction of records, making false statements, receiving
25 stolen property, making false claims, or obstruction of
26 justice; or

27 (d) Any crime in any jurisdiction which directly
28 relates to the provision of health services on a prepaid or
29 fixed-sum basis.

30 (9) The agency, after notifying the Legislature, may
31 apply for waivers of applicable federal laws and regulations

1 as necessary to implement more appropriate systems of health
2 care for Medicaid recipients and reduce the cost of the
3 Medicaid program to the state and federal governments and
4 shall implement such programs, after legislative approval,
5 within a reasonable period of time after federal approval.
6 These programs must be designed primarily to reduce the need
7 for inpatient care, custodial care and other long-term or
8 institutional care, and other high-cost services.

9 (a) Prior to seeking legislative approval of such a
10 waiver as authorized by this subsection, the agency shall
11 provide notice and an opportunity for public comment. Notice
12 shall be provided to all persons who have made requests of the
13 agency for advance notice and shall be published in the
14 Florida Administrative Weekly not less than 28 days prior to
15 the intended action.

16 (b) Notwithstanding s. 216.292, funds that are
17 appropriated to the Department of Elderly Affairs for the
18 Assisted Living for the Elderly Medicaid waiver and are not
19 expended shall be transferred to the agency to fund
20 Medicaid-reimbursed nursing home care.

21 (10) The agency shall establish a postpayment
22 utilization control program designed to identify recipients
23 who may inappropriately overuse or underuse Medicaid services
24 and shall provide methods to correct such misuse.

25 (11) The agency shall develop and provide coordinated
26 systems of care for Medicaid recipients and may contract with
27 public or private entities to develop and administer such
28 systems of care among public and private health care providers
29 in a given geographic area.

30
31

1 (12) The agency shall operate or contract for the
2 operation of utilization management and incentive systems
3 designed to encourage cost-effective use services.

4 (13)(a) The agency shall identify health care
5 utilization and price patterns within the Medicaid program
6 which are not cost-effective or medically appropriate and
7 assess the effectiveness of new or alternate methods of
8 providing and monitoring service, and may implement such
9 methods as it considers appropriate. Such methods may include
10 disease management initiatives, an integrated and systematic
11 approach for managing the health care needs of recipients who
12 are at risk of or diagnosed with a specific disease by using
13 best practices, prevention strategies, clinical-practice
14 improvement, clinical interventions and protocols, outcomes
15 research, information technology, and other tools and
16 resources to reduce overall costs and improve measurable
17 outcomes.

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

25 1. The practice pattern identification program shall
26 evaluate practitioner prescribing patterns based on national
27 and regional practice guidelines, comparing practitioners to
28 their peer groups. The agency and its Drug Utilization Review
29 Board shall consult with a panel of practicing health care
30 professionals consisting of the following: the Speaker of the
31 House of Representatives and the President of the Senate shall

1 each appoint three physicians licensed under chapter 458 or
2 chapter 459; and the Governor shall appoint two pharmacists
3 licensed under chapter 465 and one dentist licensed under
4 chapter 466 who is an oral surgeon. Terms of the panel members
5 shall expire at the discretion of the appointing official. The
6 panel shall begin its work by August 1, 1999, regardless of
7 the number of appointments made by that date. The advisory
8 panel shall be responsible for evaluating treatment guidelines
9 and recommending ways to incorporate their use in the practice
10 pattern identification program. Practitioners who are
11 prescribing inappropriately or inefficiently, as determined by
12 the agency, may have their prescribing of certain drugs
13 subject to prior authorization.

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

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

26 4. The agency may apply for any federal waivers needed
27 to implement this paragraph.

28 (14) An entity contracting on a prepaid or fixed-sum
29 basis shall, in addition to meeting any applicable statutory
30 surplus requirements, also maintain at all times in the form
31 of cash, investments that mature in less than 180 days

1 allowable as admitted assets by the Department of Insurance,
2 and restricted funds or deposits controlled by the agency or
3 the Department of Insurance, a surplus amount equal to
4 one-and-one-half times the entity's monthly Medicaid prepaid
5 revenues. As used in this subsection, the term "surplus" means
6 the entity's total assets minus total liabilities. If an
7 entity's surplus falls below an amount equal to
8 one-and-one-half times the entity's monthly Medicaid prepaid
9 revenues, the agency shall prohibit the entity from engaging
10 in marketing and preenrollment activities, shall cease to
11 process new enrollments, and shall not renew the entity's
12 contract until the required balance is achieved. The
13 requirements of this subsection do not apply:

14 (a) Where a public entity agrees to fund any deficit
15 incurred by the contracting entity; or

16 (b) Where the entity's performance and obligations are
17 guaranteed in writing by a guaranteeing organization which:

18 1. Has been in operation for at least 5 years and has
19 assets in excess of \$50 million; or

20 2. Submits a written guarantee acceptable to the
21 agency which is irrevocable during the term of the contracting
22 entity's contract with the agency and, upon termination of the
23 contract, until the agency receives proof of satisfaction of
24 all outstanding obligations incurred under the contract.

25 (15)(a) The agency may require an entity contracting
26 on a prepaid or fixed-sum basis to establish a restricted
27 insolvency protection account with a federally guaranteed
28 financial institution licensed to do business in this state.
29 The entity shall deposit into that account 5 percent of the
30 capitation payments made by the agency each month until a
31 maximum total of 2 percent of the total current contract

1 amount is reached. The restricted insolvency protection
2 account may be drawn upon with the authorized signatures of
3 two persons designated by the entity and two representatives
4 of the agency. If the agency finds that the entity is
5 insolvent, the agency may draw upon the account solely with
6 the two authorized signatures of representatives of the
7 agency, and the funds may be disbursed to meet financial
8 obligations incurred by the entity under the prepaid contract.
9 If the contract is terminated, expired, or not continued, the
10 account balance must be released by the agency to the entity
11 upon receipt of proof of satisfaction of all outstanding
12 obligations incurred under this contract.

13 (b) The agency may waive the insolvency protection
14 account requirement in writing when evidence is on file with
15 the agency of adequate insolvency insurance and reinsurance
16 that will protect enrollees if the entity becomes unable to
17 meet its obligations.

18 (16) An entity that contracts with the agency on a
19 prepaid or fixed-sum basis for the provision of Medicaid
20 services shall reimburse any hospital or physician that is
21 outside the entity's authorized geographic service area as
22 specified in its contract with the agency, and that provides
23 services authorized by the entity to its members, at a rate
24 negotiated with the hospital or physician for the provision of
25 services or according to the lesser of the following:

26 (a) The usual and customary charges made to the
27 general public by the hospital or physician; or

28 (b) The Florida Medicaid reimbursement rate
29 established for the hospital or physician.

30 (17) When a merger or acquisition of a Medicaid
31 prepaid contractor has been approved by the Department of

1 Insurance pursuant to s. 628.4615, the agency shall approve
2 the assignment or transfer of the appropriate Medicaid prepaid
3 contract upon request of the surviving entity of the merger or
4 acquisition if the contractor and the other entity have been
5 in good standing with the agency for the most recent 12-month
6 period, unless the agency determines that the assignment or
7 transfer would be detrimental to the Medicaid recipients or
8 the Medicaid program. To be in good standing, an entity must
9 not have failed accreditation or committed any material
10 violation of the requirements of s. 641.52 and must meet the
11 Medicaid contract requirements. For purposes of this section,
12 a merger or acquisition means a change in controlling interest
13 of an entity, including an asset or stock purchase.

14 (18) Any entity contracting with the agency pursuant
15 to this section to provide health care services to Medicaid
16 recipients is prohibited from engaging in any of the following
17 practices or activities:

18 (a) Practices that are discriminatory, including, but
19 not limited to, attempts to discourage participation on the
20 basis of actual or perceived health status.

21 (b) Activities that could mislead or confuse
22 recipients, or misrepresent the organization, its marketing
23 representatives, or the agency. Violations of this paragraph
24 include, but are not limited to:

25 1. False or misleading claims that marketing
26 representatives are employees or representatives of the state
27 or county, or of anyone other than the entity or the
28 organization by whom they are reimbursed.

29 2. False or misleading claims that the entity is
30 recommended or endorsed by any state or county agency, or by
31

1 any other organization which has not certified its endorsement
2 in writing to the entity.

3 3. False or misleading claims that the state or county
4 recommends that a Medicaid recipient enroll with an entity.

5 4. Claims that a Medicaid recipient will lose benefits
6 under the Medicaid program, or any other health or welfare
7 benefits to which the recipient is legally entitled, if the
8 recipient does not enroll with the entity.

9 (c) Granting or offering of any monetary or other
10 valuable consideration for enrollment, except as authorized by
11 subsection (21).

12 (d) Door-to-door solicitation of recipients who have
13 not contacted the entity or who have not invited the entity to
14 make a presentation.

15 (e) Solicitation of Medicaid recipients by marketing
16 representatives stationed in state offices unless approved and
17 supervised by the agency or its agent and approved by the
18 affected state agency when solicitation occurs in an office of
19 the state agency. The agency shall ensure that marketing
20 representatives stationed in state offices shall market their
21 managed care plans to Medicaid recipients only in designated
22 areas and in such a way as to not interfere with the
23 recipients' activities in the state office.

24 (f) Enrollment of Medicaid recipients.

25 (19) The agency may impose a fine for a violation of
26 this section or the contract with the agency by a person or
27 entity that is under contract with the agency. With respect
28 to any nonwillful violation, such fine shall not exceed \$2,500
29 per violation. In no event shall such fine exceed an
30 aggregate amount of \$10,000 for all nonwillful violations
31 arising out of the same action. With respect to any knowing

1 and willful violation of this section or the contract with the
2 agency, the agency may impose a fine upon the entity in an
3 amount not to exceed \$20,000 for each such violation. In no
4 event shall such fine exceed an aggregate amount of \$100,000
5 for all knowing and willful violations arising out of the same
6 action.

7 (20) A health maintenance organization or a person or
8 entity exempt from chapter 641 that is under contract with the
9 agency for the provision of health care services to Medicaid
10 recipients may not use or distribute marketing materials used
11 to solicit Medicaid recipients, unless such materials have
12 been approved by the agency. The provisions of this subsection
13 do not apply to general advertising and marketing materials
14 used by a health maintenance organization to solicit both
15 non-Medicaid subscribers and Medicaid recipients.

16 (21) Upon approval by the agency, health maintenance
17 organizations and persons or entities exempt from chapter 641
18 that are under contract with the agency for the provision of
19 health care services to Medicaid recipients may be permitted
20 within the capitation rate to provide additional health
21 benefits that the agency has found are of high quality, are
22 practicably available, provide reasonable value to the
23 recipient, and are provided at no additional cost to the
24 state.

25 (22) The agency shall utilize the statewide health
26 maintenance organization complaint hotline for the purpose of
27 investigating and resolving Medicaid and prepaid health plan
28 complaints, maintaining a record of complaints and confirmed
29 problems, and receiving disenrollment requests made by
30 recipients.

31

1 (23) The agency shall require the publication of the
2 health maintenance organization's and the prepaid health
3 plan's consumer services telephone numbers and the "800"
4 telephone number of the statewide health maintenance
5 organization complaint hotline on each Medicaid identification
6 card issued by a health maintenance organization or prepaid
7 health plan contracting with the agency to serve Medicaid
8 recipients and on each subscriber handbook issued to a
9 Medicaid recipient.

10 (24) The agency shall establish a health care quality
11 improvement system for those entities contracting with the
12 agency pursuant to this section, incorporating all the
13 standards and guidelines developed by the Medicaid Bureau of
14 the Health Care Financing Administration as a part of the
15 quality assurance reform initiative. The system shall
16 include, but need not be limited to, the following:

17 (a) Guidelines for internal quality assurance
18 programs, including standards for:

- 19 1. Written quality assurance program descriptions.
- 20 2. Responsibilities of the governing body for
21 monitoring, evaluating, and making improvements to care.
- 22 3. An active quality assurance committee.
- 23 4. Quality assurance program supervision.
- 24 5. Requiring the program to have adequate resources to
25 effectively carry out its specified activities.
- 26 6. Provider participation in the quality assurance
27 program.
- 28 7. Delegation of quality assurance program activities.
- 29 8. Credentialing and recredentialing.
- 30 9. Enrollee rights and responsibilities.

31

- 1 10. Availability and accessibility to services and
2 care.
- 3 11. Ambulatory care facilities.
- 4 12. Accessibility and availability of medical records,
5 as well as proper recordkeeping and process for record review.
- 6 13. Utilization review.
- 7 14. A continuity of care system.
- 8 15. Quality assurance program documentation.
- 9 16. Coordination of quality assurance activity with
10 other management activity.
- 11 17. Delivering care to pregnant women and infants; to
12 elderly and disabled recipients, especially those who are at
13 risk of institutional placement; to persons with developmental
14 disabilities; and to adults who have chronic, high-cost
15 medical conditions.
- 16 (b) Guidelines which require the entities to conduct
17 quality-of-care studies which:
- 18 1. Target specific conditions and specific health
19 service delivery issues for focused monitoring and evaluation.
- 20 2. Use clinical care standards or practice guidelines
21 to objectively evaluate the care the entity delivers or fails
22 to deliver for the targeted clinical conditions and health
23 services delivery issues.
- 24 3. Use quality indicators derived from the clinical
25 care standards or practice guidelines to screen and monitor
26 care and services delivered.
- 27 (c) Guidelines for external quality review of each
28 contractor which require: focused studies of patterns of care;
29 individual care review in specific situations; and followup
30 activities on previous pattern-of-care study findings and
31 individual-care-review findings. In designing the external

1 quality review function and determining how it is to operate
2 as part of the state's overall quality improvement system, the
3 agency shall construct its external quality review
4 organization and entity contracts to address each of the
5 following:

6 1. Delineating the role of the external quality review
7 organization.

8 2. Length of the external quality review organization
9 contract with the state.

10 3. Participation of the contracting entities in
11 designing external quality review organization review
12 activities.

13 4. Potential variation in the type of clinical
14 conditions and health services delivery issues to be studied
15 at each plan.

16 5. Determining the number of focused pattern-of-care
17 studies to be conducted for each plan.

18 6. Methods for implementing focused studies.

19 7. Individual care review.

20 8. Followup activities.

21 (25) In order to ensure that children receive health
22 care services for which an entity has already been
23 compensated, an entity contracting with the agency pursuant to
24 this section shall achieve an annual Early and Periodic
25 Screening, Diagnosis, and Treatment (EPSDT) Service screening
26 rate of at least 60 percent for those recipients continuously
27 enrolled for at least 8 months. The agency shall develop a
28 method by which the EPSDT screening rate shall be calculated.
29 For any entity which does not achieve the annual 60 percent
30 rate, the entity must submit a corrective action plan for the
31 agency's approval. If the entity does not meet the standard

1 established in the corrective action plan during the specified
2 timeframe, the agency is authorized to impose appropriate
3 contract sanctions. At least annually, the agency shall
4 publicly release the EPSDT Services screening rates of each
5 entity it has contracted with on a prepaid basis to serve
6 Medicaid recipients.

7 (26) The agency shall perform choice counseling,
8 enrollments, and disenrollments for Medicaid recipients who
9 are eligible for MediPass or managed care plans.

10 Notwithstanding the prohibition contained in paragraph
11 (18)(f), managed care plans may perform preenrollments of
12 Medicaid recipients under the supervision of the agency or its
13 agents. For the purposes of this section, "preenrollment"
14 means the provision of marketing and educational materials to
15 a Medicaid recipient and assistance in completing the
16 application forms, but shall not include actual enrollment
17 into a managed care plan. An application for enrollment shall
18 not be deemed complete until the agency or its agent verifies
19 that the recipient made an informed, voluntary choice. The
20 agency, in cooperation with the Department of Children and
21 Family Services, may test new marketing initiatives to inform
22 Medicaid recipients about their managed care options at
23 selected sites. The agency shall report to the Legislature on
24 the effectiveness of such initiatives. The agency may
25 contract with a third party to perform managed care plan and
26 MediPass choice-counseling, enrollment, and disenrollment
27 services for Medicaid recipients and is authorized to adopt
28 rules to implement such services. The agency may adjust the
29 capitation rate only to cover the costs of a third-party
30 choice-counseling, enrollment, and disenrollment contract, and
31

1 for agency supervision and management of the managed care plan
2 choice-counseling, enrollment, and disenrollment contract.

3 (27) Any lists of providers made available to Medicaid
4 recipients, MediPass enrollees, or managed care plan enrollees
5 shall be arranged alphabetically showing the provider's name
6 and specialty and, separately, by specialty in alphabetical
7 order.

8 (28) The agency shall establish an enhanced managed
9 care quality assurance oversight function, to include at least
10 the following components:

11 (a) At least quarterly analysis and followup,
12 including sanctions as appropriate, of managed care
13 participant utilization of services.

14 (b) At least quarterly analysis and followup,
15 including sanctions as appropriate, of quality findings of the
16 Medicaid peer review organization and other external quality
17 assurance programs.

18 (c) At least quarterly analysis and followup,
19 including sanctions as appropriate, of the fiscal viability of
20 managed care plans.

21 (d) At least quarterly analysis and followup,
22 including sanctions as appropriate, of managed care
23 participant satisfaction and disenrollment surveys.

24 (e) The agency shall conduct regular and ongoing
25 Medicaid recipient satisfaction surveys.

26
27 The analyses and followup activities conducted by the agency
28 under its enhanced managed care quality assurance oversight
29 function shall not duplicate the activities of accreditation
30 reviewers for entities regulated under part III of chapter
31

1 641, but may include a review of the finding of such
2 reviewers.

3 (29) Each managed care plan that is under contract
4 with the agency to provide health care services to Medicaid
5 recipients shall annually conduct a background check with the
6 Florida Department of Law Enforcement of all persons with
7 ownership interest of 5 percent or more or executive
8 management responsibility for the managed care plan and shall
9 submit to the agency information concerning any such person
10 who has been found guilty of, regardless of adjudication, or
11 has entered a plea of nolo contendere or guilty to, any of the
12 offenses listed in s. 435.03.

13 (30) The agency shall, by rule, develop a process
14 whereby a Medicaid managed care plan enrollee who wishes to
15 enter hospice care may be disenrolled from the managed care
16 plan within 24 hours after contacting the agency regarding
17 such request. The agency rule shall include a methodology for
18 the agency to recoup managed care plan payments on a pro rata
19 basis if payment has been made for the enrollment month when
20 disenrollment occurs.

21 (31) The agency and entities which contract with the
22 agency to provide health care services to Medicaid recipients
23 under this section or s. 409.9122 must comply with the
24 provisions of s. 641.513 in providing emergency services and
25 care to Medicaid recipients and MediPass recipients.

26 (32) All entities providing health care services to
27 Medicaid recipients shall make available, and encourage all
28 pregnant women and mothers with infants to receive, and
29 provide documentation in the medical records to reflect, the
30 following:

31 (a) Healthy Start prenatal or infant screening.

1 (b) Healthy Start care coordination, when screening or
2 other factors indicate need.

3 (c) Healthy Start enhanced services in accordance with
4 the prenatal or infant screening results.

5 (d) Immunizations in accordance with recommendations
6 of the Advisory Committee on Immunization Practices of the
7 United States Public Health Service and the American Academy
8 of Pediatrics, as appropriate.

9 (e) Counseling and services for family planning to all
10 women and their partners.

11 (f) A scheduled postpartum visit for the purpose of
12 voluntary family planning, to include discussion of all
13 methods of contraception, as appropriate.

14 (g) Referral to the Special Supplemental Nutrition
15 Program for Women, Infants, and Children (WIC).

16 (33) Any entity that provides Medicaid prepaid health
17 plan services shall ensure the appropriate coordination of
18 health care services with an assisted living facility in cases
19 where a Medicaid recipient is both a member of the entity's
20 prepaid health plan and a resident of the assisted living
21 facility. If the entity is at risk for Medicaid targeted case
22 management and behavioral health services, the entity shall
23 inform the assisted living facility of the procedures to
24 follow should an emergent condition arise.

25 (34) The agency may seek and implement federal waivers
26 necessary to provide for cost-effective purchasing of home
27 health services, private duty nursing services,
28 transportation, independent laboratory services, and durable
29 medical equipment and supplies through competitive bidding
30 ~~negotiation~~ pursuant to s. 287.057. The agency may request
31 appropriate waivers from the federal Health Care Financing

1 Administration in order to competitively bid such home health
2 services. The agency may exclude providers not selected
3 through the bidding process from the Medicaid provider
4 network.

5 (35) The Agency for Health Care Administration is
6 directed to issue a request for proposal or intent to
7 negotiate to implement on a demonstration basis an outpatient
8 specialty services pilot project in a rural and urban county
9 in the state. As used in this subsection, the term
10 "outpatient specialty services" means clinical laboratory,
11 diagnostic imaging, and specified home medical services to
12 include durable medical equipment, prosthetics and orthotics,
13 and infusion therapy.

14 (a) The entity that is awarded the contract to provide
15 Medicaid managed care outpatient specialty services must, at a
16 minimum, meet the following criteria:

17 1. The entity must be licensed by the Department of
18 Insurance under part II of chapter 641.

19 2. The entity must be experienced in providing
20 outpatient specialty services.

21 3. The entity must demonstrate to the satisfaction of
22 the agency that it provides high-quality services to its
23 patients.

24 4. The entity must demonstrate that it has in place a
25 complaints and grievance process to assist Medicaid recipients
26 enrolled in the pilot managed care program to resolve
27 complaints and grievances.

28 (b) The pilot managed care program shall operate for a
29 period of 3 years. The objective of the pilot program shall
30 be to determine the cost-effectiveness and effects on
31 utilization, access, and quality of providing outpatient

1 specialty services to Medicaid recipients on a prepaid,
2 capitated basis.

3 (c) The agency shall conduct a quality assurance
4 review of the prepaid health clinic each year that the
5 demonstration program is in effect. The prepaid health clinic
6 is responsible for all expenses incurred by the agency in
7 conducting a quality assurance review.

8 (d) The entity that is awarded the contract to provide
9 outpatient specialty services to Medicaid recipients shall
10 report data required by the agency in a format specified by
11 the agency, for the purpose of conducting the evaluation
12 required in paragraph (e).

13 (e) The agency shall conduct an evaluation of the
14 pilot managed care program and report its findings to the
15 Governor and the Legislature by no later than January 1, 2001.

16 (36) The agency shall enter into agreements with
17 not-for-profit organizations based in this state for the
18 purpose of providing vision screening.

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

22 1. Medicaid prescribed-drug coverage for brand-name
23 drugs for adult Medicaid recipients ~~not residing in nursing~~
24 ~~homes or other institutions~~ is limited to the dispensing of
25 four brand-name drugs per month per recipient. Children ~~and~~
26 ~~institutionalized adults~~ are exempt from this restriction.
27 Antiretroviral agents are excluded from this limitation. No
28 requirements for prior authorization or other restrictions on
29 medications used to treat mental illnesses such as
30 schizophrenia, severe depression, or bipolar disorder may be
31 imposed on Medicaid recipients. Medications that will be

1 available without restriction for persons with mental
2 illnesses include atypical antipsychotic medications,
3 conventional antipsychotic medications, selective serotonin
4 reuptake inhibitors, and other medications used for the
5 treatment of serious mental illnesses. The agency shall also
6 limit the amount of a prescribed drug dispensed to no more
7 than a 34-day supply. The agency shall continue to provide
8 unlimited generic drugs, contraceptive drugs and items, and
9 diabetic supplies. Although a drug may be included on the
10 preferred drug formulary, it would not be exempt from the
11 four-brand limit.The agency may authorize exceptions to the
12 brand-name-drug restriction based upon the treatment needs of
13 the patients, only when such exceptions are based on prior
14 consultation provided by the agency or an agency contractor,
15 but the agency must establish procedures to ensure that:

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

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

24 c. Except for the exception for nursing home residents
25 and other institutionalized adults and except for drugs on the
26 restricted formulary for which prior authorization may be
27 sought by an institutional or community pharmacy, prior
28 authorization for an exception to the brand-name-drug
29 restriction is sought by the prescriber and not by the
30 pharmacy. When prior authorization is granted for a patient in
31 an institutional setting beyond the brand-name-drug

1 restriction, such approval is authorized for 12 months and
2 monthly prior authorization is not required for that patient.

3 2. Reimbursement to pharmacies for Medicaid prescribed
4 drugs shall be set at the average wholesale price less 13.25
5 percent.

6 3. The agency shall develop and implement a process
7 for managing the drug therapies of Medicaid recipients who are
8 using significant numbers of prescribed drugs each month. The
9 management process may include, but is not limited to,
10 comprehensive, physician-directed medical-record reviews,
11 claims analyses, and case evaluations to determine the medical
12 necessity and appropriateness of a patient's treatment plan
13 and drug therapies. The agency may contract with a private
14 organization to provide drug-program-management services. The
15 Medicaid drug benefit management program shall include
16 initiatives to manage drug therapies for HIV/AIDS patients,
17 patients using 20 or more unique prescriptions in a 180-day
18 period, and the top 1,000 patients in annual spending.

19 4. The agency may limit the size of its pharmacy
20 network based on need, competitive bidding, price
21 negotiations, credentialing, or similar criteria. The agency
22 shall give special consideration to rural areas in determining
23 the size and location of pharmacies included in the Medicaid
24 pharmacy network. A pharmacy credentialing process may include
25 criteria such as a pharmacy's full-service status, location,
26 size, patient educational programs, patient consultation,
27 disease-management services, and other characteristics. The
28 agency may impose a moratorium on Medicaid pharmacy enrollment
29 when it is determined that it has a sufficient number of
30 Medicaid-participating providers.

31

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

10 6. The agency may enter into arrangements that require
11 manufacturers of generic drugs prescribed to Medicaid
12 recipients to provide rebates of at least 15.1 percent of the
13 average manufacturer price for the manufacturer's generic
14 products. These arrangements shall require that if a
15 generic-drug manufacturer pays federal rebates for
16 Medicaid-reimbursed drugs at a level below 15.1 percent, the
17 manufacturer must provide a supplemental rebate to the state
18 in an amount necessary to achieve a 15.1-percent rebate level.
19 ~~If a generic drug manufacturer raises its price in excess of~~
20 ~~the Consumer Price Index (Urban), the excess amount shall be~~
21 ~~included in the supplemental rebate to the state.~~

22 7. The agency may establish a preferred drug formulary
23 in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the
24 establishment of such formulary, it is authorized to negotiate
25 supplemental rebates from manufacturers that are in addition
26 to those required by Title XIX of the Social Security Act and
27 at no less than 10 percent of the average manufacturer price
28 as defined in 42 U.S.C. s. 1936 on the last day of a quarter
29 unless the federal or supplemental rebate, or both, equals or
30 exceeds 25 percent. There is no upper limit on the
31 supplemental rebates the agency may negotiate. The agency may

1 determine that specific products, brand-name or generic, are
2 competitive at lower rebate percentages. Agreement to pay the
3 minimum supplemental rebate percentage will guarantee a
4 manufacturer that the Medicaid Pharmaceutical and Therapeutics
5 Committee will consider a product for inclusion on the
6 preferred drug formulary. However, a pharmaceutical
7 manufacturer is not guaranteed placement on the formulary by
8 simply paying the minimum supplemental rebate. Agency
9 decisions will be made on the clinical efficacy of a drug and
10 recommendations of the Medicaid Pharmaceutical and
11 Therapeutics Committee, as well as the price of competing
12 products minus federal and state rebates. The agency is
13 authorized to contract with an outside agency or contractor to
14 conduct negotiations for supplemental rebates. For the
15 purposes of this section, the term "supplemental rebates" may
16 include, at the agency's discretion, cash rebates and other
17 program benefits that offset a Medicaid expenditure. Such
18 other program benefits may include, but are not limited to,
19 disease management programs, drug product donation programs,
20 drug utilization control programs, prescriber and beneficiary
21 counseling and education, fraud and abuse initiatives, and
22 other services or administrative investments with guaranteed
23 savings to the Medicaid program in the same year the rebate
24 reduction is included in the General Appropriations Act. The
25 agency is authorized to seek any federal waivers to implement
26 this initiative.

27 8. The agency shall establish an advisory committee
28 for the purposes of studying the feasibility of using a
29 restricted drug formulary for nursing home residents and other
30 institutionalized adults. The committee shall be comprised of
31 seven members appointed by the Secretary of Health Care

1 Administration. The committee members shall include two
2 physicians licensed under chapter 458 or chapter 459, Florida
3 Statutes; three pharmacists licensed under chapter 465,
4 Florida Statutes, and appointed from a list of recommendations
5 provided by the Florida Long-Term Care Pharmacy Alliance; and
6 two pharmacists licensed under chapter 465, Florida Statutes.

7 (b) The agency shall implement this subsection to the
8 extent that funds are appropriated to administer the Medicaid
9 prescribed-drug spending-control program. The agency may
10 contract all or any part of this program to private
11 organizations.

12 (c) The agency shall submit a report to the Governor,
13 the President of the Senate, and the Speaker of the House of
14 Representatives by January 15 of each year. The report must
15 include, but need not be limited to, the progress made in
16 implementing Medicaid cost-containment measures and their
17 effect on Medicaid prescribed-drug expenditures.

18 (38) Notwithstanding the provisions of chapter 287,
19 the agency may, at its discretion, renew a contract or
20 contracts for fiscal intermediary services one or more times
21 for such periods as the agency may decide; however, all such
22 renewals may not combine to exceed a total period longer than
23 the term of the original contract.

24 (39) The agency shall provide for the development of a
25 demonstration project by establishment in Miami-Dade County of
26 a long-term-care facility licensed pursuant to chapter 395 to
27 improve access to health care for a predominantly minority,
28 medically underserved, and medically complex population and to
29 evaluate alternatives to nursing-home care and general acute
30 care for such population. Such project is to be located in a
31 health care condominium and colocated with licensed facilities

1 providing a continuum of care. The establishment of this
2 project is not subject to the provisions of s. 408.036 or s.
3 408.039. The agency shall report its findings to the
4 Governor, the President of the Senate, and the Speaker of the
5 House of Representatives by January 1, 2003.

6 Section 10. Paragraphs (f) and (k) of subsection (2)
7 of section 409.9122, Florida Statutes, are amended to read:

8 409.9122 Mandatory Medicaid managed care enrollment;
9 programs and procedures.--

10 (2)

11 (f) When a Medicaid recipient does not choose a
12 managed care plan or MediPass provider, the agency shall
13 assign the Medicaid recipient to a managed care plan or
14 MediPass provider. Medicaid recipients who are subject to
15 mandatory assignment but who fail to make a choice shall be
16 assigned to managed care plans or provider service networks
17 until an equal enrollment of 50 percent in MediPass and
18 provider service networks and 50 percent in managed care plans
19 is achieved. Once equal enrollment is achieved, the
20 assignments shall be divided in order to maintain an equal
21 enrollment in MediPass and managed care plans ~~for the~~
22 ~~1998-1999 fiscal year~~. Thereafter, assignment of Medicaid
23 recipients who fail to make a choice shall be based
24 proportionally on the preferences of recipients who have made
25 a choice in the previous period. Such proportions shall be
26 revised at least quarterly to reflect an update of the
27 preferences of Medicaid recipients. The agency shall also
28 disproportionately assign Medicaid-eligible children in
29 families who are required to but have failed to make a choice
30 of managed-care plan or MediPass for their child and who are
31 to be assigned to the MediPass program to children's networks

1 as described in s. 409.912(3)(g) and where available. The
2 disproportionate assignment of children to children's networks
3 shall be made until the agency has determined that the
4 children's networks have sufficient numbers to be economically
5 operated.When making assignments, the agency shall take into
6 account the following criteria:

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

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

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

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

20 ~~(k)1. Notwithstanding the provisions of paragraph (f),~~
21 ~~and for the 2000-2001 fiscal year only,~~When a Medicaid
22 recipient does not choose a managed care plan or MediPass
23 provider, the agency shall assign the Medicaid recipient to a
24 managed care plan, except in those counties in which there are
25 fewer than two managed care plans accepting Medicaid
26 enrollees, in which case assignment shall be to a managed care
27 plan or a MediPass provider. Medicaid recipients in counties
28 with fewer than two managed care plans accepting Medicaid
29 enrollees who are subject to mandatory assignment but who fail
30 to make a choice shall be assigned to managed care plans until
31 an equal enrollment of 50 percent in MediPass and provider

1 service networks and 50 percent in managed care plans is
2 achieved. Once equal enrollment is achieved, the assignments
3 shall be divided in order to maintain an equal enrollment in
4 MediPass and managed care plans. When making assignments, the
5 agency shall take into account the following criteria:

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

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

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

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

19 5.e. The agency has authority to make mandatory
20 assignments based on quality of service and performance of
21 managed care plans.

22 ~~2. This paragraph is repealed on July 1, 2001.~~

23 Section 11. Paragraph (a) of subsection (1) and
24 subsection (7) of section 409.915, Florida Statutes, are
25 amended to read:

26 409.915 County contributions to Medicaid.--Although
27 the state is responsible for the full portion of the state
28 share of the matching funds required for the Medicaid program,
29 in order to acquire a certain portion of these funds, the
30 state shall charge the counties for certain items of care and
31 service as provided in this section.

1 (1) Each county shall participate in the following
2 items of care and service:

3 (a) For both health maintenance members and
4 fee-for-service beneficiaries, payments for inpatient
5 hospitalization in excess of 10 ~~12~~ days, but not in excess of
6 45 days, with the exception of pregnant women and children
7 whose income is in excess of the federal poverty level and who
8 do not participate in the Medicaid medically needy program.

9 (7) Counties are exempt from contributing toward the
10 cost of new exemptions on inpatient ceilings for statutory
11 teaching hospitals, specialty hospitals, and community
12 hospital education program hospitals that came into effect
13 July 1, 2000, and for special Medicaid payments that came into
14 effect on or after July 1, 2000.~~Notwithstanding any provision~~
15 ~~of this section to the contrary, counties are exempt from~~
16 ~~contributing toward the increased cost of hospital inpatient~~
17 ~~services due to the elimination of ceilings on Medicaid~~
18 ~~inpatient reimbursement rates paid to teaching hospitals,~~
19 ~~specialty hospitals, and community health education program~~
20 ~~hospitals and for special Medicaid reimbursements to hospitals~~
21 ~~for which the Legislature has specifically appropriated funds.~~
22 ~~This subsection is repealed on July 1, 2001.~~

23 Section 12. Effective upon this act becoming a law,
24 and notwithstanding sections 409.911, 409.9113, and 409.9117,
25 Florida Statutes, from the funds made available under the
26 Medicare program, the Medicaid program, and the State
27 Children's Health Insurance Program Benefits Improvement and
28 Protection Act of 2000 for the 2001 federal fiscal year,
29 disproportionate share program funds shall be distributed as
30 follows: \$13,937,997 to Jackson Memorial; \$285,298 to Mount
31 Sinai Medical Center; \$313,748 to Orlando Regional Medical

1 Center; \$2,734,019 to Shands - Jacksonville; \$1,060,047 to
 2 Shands - University of Florida; \$1,683,415 to Tampa General
 3 Hospital; and \$2,231,910 to North Broward Hospital District.
 4 Such funds shall be made available in accordance with a budget
 5 amendment and the Medicaid plan amendment submitted prior to
 6 the close of the 2001 federal fiscal year. This section does
 7 not delay implementation of the budget amendment or the
 8 Medicaid plan amendment if such is deemed necessary.

9 Section 13. From the funds in Specific Appropriation
 10 1002 of the General Appropriations Act for FY 2001-2002,
 11 \$1,750,000 in non-recurring County Health Department Trust
 12 Funds is provided for the following:

14 <u>School Health--Hillsborough County</u>	<u>\$550,000</u>
15 <u>School Health--Broward County</u>	<u>\$500,000</u>
16 <u>School Health--Escambia County</u>	<u>\$200,000</u>
17 <u>School Health--Monroe County</u>	<u>\$200,000</u>
18 <u>School Health--Dade County</u>	<u>\$300,000</u>

19 Section 14. The certificate-of-need workgroup created
 20 by section 15 of Chapter 2000-318, Laws of Florida, shall
 21 review and make recommendations regarding the appropriateness
 22 of current regulations on services provided in ambulatory
 23 surgical centers. The recommendations shall be based on
 24 consideration of:

25 (1) The consistency of the regulations with federal
 26 law and federal reimbursement policies;

27 (2) The effectiveness of the regulations in protecting
 28 the public health and safety, promoting the quality of
 29 services provided by ambulatory surgical centers, and
 30 encouraging the participation of ambulatory surgical centers
 31 in the delivery of essential community services; and

1 (3) The impact of any change of the current
2 regulations on the health care market, including:

3 (a) The number and location of facilities and
4 services, whether provided by an ambulatory surgical center or
5 other licensed health care provider;

6 (b) The financial condition of safety net providers;

7 (c) The availability of essential community services,
8 including trauma, emergency care and specialty, tertiary
9 services; and

10 (d) The cost and availability of health care services
11 to all classes of patients, including insured, uninsured,
12 underinsured, and Medicare and Medicaid.

13 Section 15. Paragraphs (r) and (s) are added to
14 subsection (3) of section 408.036, Florida Statutes, to read:

15 408.036 Projects subject to review.--

16 (3) EXEMPTIONS.--Upon request, the following projects
17 are subject to exemption from the provisions of subsection
18 (1):

19 (r) For the conversion of hospital-based Medicare and
20 Medicaid certified skilled nursing beds to acute care beds, if
21 the conversion does not involve the construction of new
22 facilities.

23 (s) For fiscal year 2001-2002 only, for transfer by a
24 health care system of existing services and not more than 100
25 licensed and approved beds from a hospital in district 1,
26 subdistrict 1, to another location within the same subdistrict
27 in order to establish a satellite facility that will improve
28 access to outpatient and inpatient care for residents of the
29 district and subdistrict and that will use new medical
30 technologies, including advanced diagnostics, computer

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1 assisted imaging, and telemedicine to improve care. This
 2 paragraph is repealed on July 1, 2002.

3 Section 16. It is hereby appropriated for state fiscal
 4 year 2001-2002, \$713,493 from the General Revenue Fund and
 5 \$924,837 from the Medical Care Trust Fund to increase the
 6 pharmaceutical dispensing fee for prescriptions dispensed to
 7 nursing home residents and other institutional residents from
 8 \$4.23 to \$4.73 per prescription.

9 Section 17. From the funds in Specific Appropriation
 10 500 of the General Appropriations Act for FY 2001-2002,
 11 \$196,000 in General Revenue is provided for the following:

13 <u>Public Guardianship Program - Dade County</u>	<u>\$150,000</u>
14	
15 <u>Public Guardianship Program - Collier County</u>	<u>\$ 38,000</u>
16	
17 <u>Public Guardianship Program - Escambia County</u>	<u>\$ 8,000</u>

18 Section 18. Subsection (1) and paragraph (a) of
 19 subsection (7) of section 240.4075, Florida Statutes, are
 20 amended to read:

21 240.4075 Nursing Student Loan Forgiveness Program.--

22 (1) To encourage qualified personnel to seek
 23 employment in areas of this state in which critical nursing
 24 shortages exist, there is established the Nursing Student Loan
 25 Forgiveness Program. The primary function of the program is
 26 to increase employment and retention of registered nurses and
 27 licensed practical nurses in nursing homes and hospitals in
 28 the state and in state-operated medical and health care
 29 facilities, birth centers, federally sponsored community
 30 health centers, ~~and~~ teaching hospitals, family practice
 31 teaching hospitals, and specialty children's hospitals by

1 making repayments toward loans received by students from
2 federal or state programs or commercial lending institutions
3 for the support of postsecondary study in accredited or
4 approved nursing programs.

5 (7)(a) Funds contained in the Nursing Student Loan
6 Forgiveness Trust Fund which are to be used for loan
7 forgiveness for those nurses employed by hospitals, birth
8 centers, and nursing homes must be matched on a
9 dollar-for-dollar basis by contributions from the employing
10 institutions, except that this provision shall not apply to
11 state-operated medical and health care facilities, county
12 health departments, federally sponsored community health
13 centers, ~~or~~ teaching hospitals as defined in s. 408.07, family
14 practice teaching hospitals as defined in s. 395.805, or
15 specialty children's hospitals as described in s. 409.9119.
16 If, in any given fiscal quarter, there are insufficient funds
17 in the trust fund to grant all eligible applicants' requests,
18 awards must be based on the following priority by employer:
19 county health departments, federally sponsored community
20 health centers, state-operated medical and health care
21 facilities, teaching hospitals as defined in s. 408.07, family
22 practice teaching hospitals as defined in s. 395.805,
23 specialty children's hospitals as described in s. 409.9119,
24 and other hospitals, birthing centers, or nursing homes where
25 the match is required.

26 Section 19. Paragraph (b) of subsection (4) of section
27 240.4076, Florida Statutes, is amended to read:

28 240.4076 Nursing scholarship program.--

29 (4) Credit for repayment of a scholarship shall be as
30 follows:

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1 (b) Eligible health care facilities include
2 state-operated medical or health care facilities, county
3 health departments, federally sponsored community health
4 centers, ~~or~~ teaching hospitals as defined in s. 408.07,
5 nursing homes, family practice teaching hospitals as defined
6 in s. 395.805, or specialty children's hospitals as described
7 in s. 409.9119. The recipient shall be encouraged to complete
8 the service obligation at a single employment site. If
9 continuous employment at the same site is not feasible, the
10 recipient may apply to the department for a transfer to
11 another approved health care facility.

12 Section 20. All the statutory powers, duties, and
13 functions and the records, personnel, property, and unexpended
14 balances of appropriations, allocations, or other funds of the
15 Nursing Student Loan Forgiveness Program are transferred from
16 the Department of Education to the Department of Health by a
17 type two transfer as defined in section 20.06, Florida
18 Statutes.

19 Section 21. Except as otherwise expressly provided in
20 this act, this act shall take effect July 1, 2001.

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