

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.; prohibiting nursing home
28 reimbursement rate increases associated with
29 changes in ownership; modifying requirements
30 for nursing home cost reporting; requiring a
31 report; revising standards, guidelines, and

1 limitations relating to reimbursement of
2 Medicaid providers; amending s. 409.911, F.S.;
3 updating data requirements and share rates for
4 disproportionate share distributions; amending
5 s. 409.9116, F.S.; modifying the formula for
6 disproportionate share/financial assistance
7 distribution to rural hospitals; amending s.
8 409.91195, F.S.; requiring the Medicaid
9 Pharmaceutical and Therapeutics Committee to
10 recommend a preferred drug formulary; revising
11 the membership of the Medicaid Pharmaceutical
12 and Therapeutics Committee; providing for
13 committee responsibilities; requiring the
14 agency to publish the preferred drug formulary;
15 providing for a hearing process; amending s.
16 409.912, F.S.; authorizing the agency to
17 establish requirements for prior authorization
18 for certain populations, drug classes, or
19 particular drugs; specifying conditions under
20 which the agency may enter certain contracts
21 with exclusive provider organizations; revising
22 components of the agency's spending-control
23 program; prescribing additional services that
24 the agency may provide through competitive
25 bidding; authorizing the agency to establish,
26 and make exceptions to, a restricted-drug
27 formulary; directing the agency to establish a
28 demonstration project in Miami-Dade County to
29 provide minority health care; amending s.
30 409.9122, F.S.; providing for disproportionate
31 assignment of certain Medicaid-eligible

1 children to children's clinic networks;
2 providing for assignment of certain Medicaid
3 recipients to managed-care plans; amending s.
4 409.915, F.S.; exempting counties from
5 contributing toward the increased cost of
6 hospital inpatient services due to elimination
7 of Medicaid ceilings on certain types of
8 hospitals and for special Medicaid
9 reimbursement to hospitals; revising the level
10 of county participation; providing for
11 distribution of funds under the
12 disproportionate share program for specified
13 hospitals for the 2001 federal fiscal year;
14 providing for the distribution of County Health
15 Department Trust Funds; requiring the
16 certificate-of-need workgroup to review and
17 make recommendations regarding specified
18 regulations; providing for a temporary rate
19 reduction; providing for an exemption from
20 review for transfer of certain beds and
21 services to a satellite facility; providing for
22 future repeal; providing an appropriation;
23 amending s. 408.036, F.S.; exempting specified
24 projects from required review by the Agency for
25 Health Care Administration; providing that the
26 act fulfills an important state interest;
27 amending ss. 240.4075, 240.4076, F.S.;
28 including nursing homes, family practice
29 teaching hospitals and specialty children's
30 hospitals as facilities eligible under the
31 program; exempting such hospitals from the

1 fund-matching requirements of the program;
2 transferring the program from the Board of
3 Regents to the Department of Health; providing
4 effective dates.

5
6 Be It Enacted by the Legislature of the State of Florida:

7
8 Section 1. Subsections (9), (10), and (11) are added
9 to section 409.904, Florida Statutes, to read:

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

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

21 (10) Eligible women with incomes below 200 percent of
22 the federal poverty level and under age 65, for cancer
23 treatment pursuant to the federal Breast and Cervical Cancer
24 Prevention and Treatment Act of 2000, screened through the
25 National Breast and Cervical Cancer Early Detection program.

26 (11) Subject to specific federal authorization, a
27 person who, but for earnings in excess of the limit
28 established under s. 1905(q)(2)(B) of the Social Security Act,
29 would be considered for receiving supplemental security
30 income, who is at least 16 but less than 65 years of age, and
31 whose assets, resources, and earned or unearned income, or

1 both, do not exceed 250 percent of the most current federal
2 poverty level. Such persons may be eligible for Medicaid
3 services as part of a Medicaid buy-in established under s.
4 409.914(2) specifically designed to accommodate those persons
5 made eligible for such a buy-in by Title II of Pub. L. No.
6 106-170. Such buy-in shall include income-related premiums and
7 cost sharing.

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

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

24 409.905 Mandatory Medicaid services.--The agency may
25 make payments for the following services, which are required
26 of the state by Title XIX of the Social Security Act,
27 furnished by Medicaid providers to recipients who are
28 determined to be eligible on the dates on which the services
29 were provided. Any service under this section shall be
30 provided only when medically necessary and in accordance with
31 state and federal law. Nothing in this section shall be

1 construed to prevent or limit the agency from adjusting fees,
2 reimbursement rates, lengths of stay, number of visits, number
3 of services, or any other adjustments necessary to comply with
4 the availability of moneys and any limitations or directions
5 provided for in the General Appropriations Act or chapter 216.

6 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay
7 for all covered services provided for the medical care and
8 treatment of a recipient who is admitted as an inpatient by a
9 licensed physician or dentist to a hospital licensed under
10 part I of chapter 395. However, the agency shall limit the
11 payment for inpatient hospital services for a Medicaid
12 recipient 21 years of age or older to 45 days or the number of
13 days necessary to comply with the General Appropriations Act.

14 (a) The agency is authorized to implement
15 reimbursement and utilization management reforms in order to
16 comply with any limitations or directions in the General
17 Appropriations Act, which may include, but are not limited to:
18 prior authorization for inpatient psychiatric days; prior
19 authorization for nonemergency hospital inpatient admissions
20 for individuals 21 years of age and older; authorization of
21 emergency and urgent-care admissions within 24 hours after
22 admission;enhanced utilization and concurrent review programs
23 for highly utilized services; reduction or elimination of
24 covered days of service; adjusting reimbursement ceilings for
25 variable costs; adjusting reimbursement ceilings for fixed and
26 property costs; and implementing target rates of increase. The
27 agency may limit prior authorization for hospital inpatient
28 services to selected diagnosis-related groups, based on an
29 analysis of the cost and potential for unnecessary
30 hospitalizations represented by certain diagnoses. Admissions
31 for normal delivery and newborns are exempt from requirements

1 for prior authorization. In implementing the provisions of
2 this section related to prior authorization, the agency shall
3 ensure that the process for authorization is accessible 24
4 hours per day, 7 days per week and authorization is
5 automatically granted when not denied within 4 hours after the
6 request. Authorization procedures must include steps for
7 review of denials. Upon implementing the prior authorization
8 program for hospital inpatient services, the agency shall
9 discontinue its hospital retrospective review program.

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

1 support programs, plans of the hospital to ensure the earliest
2 discharge possible, and the comprehensiveness of the mental
3 health and other health care services offered by participating
4 providers.

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

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

13 2. The hospital's Medicaid per diem rate is at least
14 25 percent below the Medicaid per patient cost for that year.

15

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

27 Section 4. Subsection (8) of section 409.906, Florida
28 Statutes, is amended, and subsection (25) is added to that
29 section, to read:

30 409.906 Optional Medicaid services.--Subject to
31 specific appropriations, the agency may make payments for

1 services which are optional to the state under Title XIX of
2 the Social Security Act and are furnished by Medicaid
3 providers to recipients who are determined to be eligible on
4 the dates on which the services were provided. Any optional
5 service that is provided shall be provided only when medically
6 necessary and in accordance with state and federal law.
7 Nothing in this section shall be construed to prevent or limit
8 the agency from adjusting fees, reimbursement rates, lengths
9 of stay, number of visits, or number of services, or making
10 any other adjustments necessary to comply with the
11 availability of moneys and any limitations or directions
12 provided for in the General Appropriations Act or chapter 216.
13 If necessary to safeguard the state's systems of providing
14 services to elderly and disabled persons and subject to the
15 notice and review provisions of s. 216.177, the Governor may
16 direct the Agency for Health Care Administration to amend the
17 Medicaid state plan to delete the optional Medicaid service
18 known as "Intermediate Care Facilities for the Developmentally
19 Disabled." Optional services may include:
20 (8) COMMUNITY MENTAL HEALTH SERVICES.--
21 (a) The agency may pay for rehabilitative services
22 provided to a recipient by a mental health or substance abuse
23 provider ~~licensed by the agency~~ and under contract with the
24 agency or the Department of Children and Family Services to
25 provide such services. Those services which are psychiatric
26 in nature shall be rendered or recommended by a psychiatrist,
27 and those services which are medical in nature shall be
28 rendered or recommended by a physician or psychiatrist. The
29 agency must develop a provider enrollment process for
30 community mental health providers which bases provider
31 enrollment on an assessment of service need. The provider

1 enrollment process shall be designed to control costs, prevent
2 fraud and abuse, consider provider expertise and capacity, and
3 assess provider success in managing utilization of care and
4 measuring treatment outcomes. Providers will be selected
5 through a competitive procurement or selective contracting
6 process. In addition to other community mental health
7 providers, the agency shall consider for enrollment mental
8 health programs licensed under chapter 395 and group practices
9 licensed under chapter 458, chapter 459, chapter 490, or
10 chapter 491. The agency is also authorized to continue
11 operation of its behavioral health utilization management
12 program and may develop new services if these actions are
13 necessary to ensure savings from the implementation of the
14 utilization management system. The agency shall coordinate the
15 implementation of this enrollment process with the Department
16 of Children and Family Services and the Department of Juvenile
17 Justice. The agency is authorized to utilize diagnostic
18 criteria in setting reimbursement rates, to preauthorize
19 certain high-cost or highly utilized services, to limit or
20 eliminate coverage for certain services, or to make any other
21 adjustments necessary to comply with any limitations or
22 directions provided for in the General Appropriations Act.

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

31

1 (25) ASSISTIVE-CARE SERVICES.--The agency may pay for
2 assistive-care services provided to recipients with functional
3 or cognitive impairments residing in assisted living
4 facilities, adult family-care homes, or residential treatment
5 facilities. These services may include health support,
6 assistance with the activities of daily living and the
7 instrumental acts of daily living, assistance with medication
8 administration, and arrangements for health care.

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

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

1 availability of moneys and any limitations or directions
2 provided for in the General Appropriations Act, provided the
3 adjustment is consistent with legislative intent.

4 (1) Reimbursement to hospitals licensed under part I
5 of chapter 395 must be made prospectively or on the basis of
6 negotiation.

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

9 1. The raising of rate reimbursement caps, excluding
10 rural hospitals.

11 2. Recognition of the costs of graduate medical
12 education.

13 3. Other methodologies recognized in the General
14 Appropriations Act.

15 4. Hospital inpatient rates shall be reduced by 6
16 percent effective July 1, 2001 and restored effective April 1,
17 2002.

18
19 During the years funds are transferred from the Department of
20 Health Board of Regents, any reimbursement supported by such
21 funds shall be subject to certification by the Department of
22 Health Board of Regents that the hospital has complied with s.
23 381.0403. The agency is authorized to receive funds from state
24 entities, including, but not limited to, the Department of
25 Health Board of Regents, local governments, and other local
26 political subdivisions, for the purpose of making special
27 exception payments, including federal matching funds, through
28 the Medicaid inpatient reimbursement methodologies. Funds
29 received from state entities or local governments for this
30 purpose shall be separately accounted for and shall not be
31 commingled with other state or local funds in any manner. The

1 agency may certify all local governmental funds used as state
2 match under Title XIX of the Social Security Act, to the
3 extent that the identified local health care provider that is
4 otherwise entitled to and is contracted to receive such local
5 funds is the benefactor under the state's Medicaid program as
6 determined under the General Appropriations Act and pursuant
7 to an agreement between the Agency for Health Care
8 Administration and the local governmental entity. The local
9 governmental entity shall use a certification form prescribed
10 by the agency. At a minimum, the certification form shall
11 identify the amount being certified and describe the
12 relationship between the certifying local governmental entity
13 and the local health care provider. The agency shall prepare
14 an annual statement of impact which documents the specific
15 activities undertaken during the previous fiscal year pursuant
16 to this paragraph, to be submitted to the Legislature no later
17 than January 1, annually.~~Notwithstanding this section and s.~~
18 ~~409.915, counties are exempt from contributing toward the cost~~
19 ~~of the special exception reimbursement for hospitals serving a~~
20 ~~disproportionate share of low-income persons and providing~~
21 ~~graduate medical education.~~

22 (2)

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

1 1. Changes of ownership or of licensed operator do not
2 qualify for increases in reimbursement rates associated with
3 the change of ownership or of licensed operator. The agency
4 shall amend the Title XIX Long Term Care Reimbursement Plan to
5 provide that the initial nursing home reimbursement rates, for
6 the operating, patient care, and MAR components, associated
7 with related and unrelated party changes of ownership or
8 licensed operator filed on or after September 1, 2001, are
9 equivalent to the previous owner's reimbursement rate.

10 2. The agency shall amend the long-term care
11 reimbursement plan and cost reporting system to create direct
12 care and indirect care subcomponents of the patient care
13 component of the per diem rate. These two subcomponents
14 together shall equal the patient care component of the per
15 diem rate. Separate cost-based ceilings shall be calculated
16 for each patient care subcomponent. The direct care
17 subcomponent of the per diem rate shall be limited by the
18 cost-based class ceiling and the indirect care subcomponent
19 shall be limited by the lower of the cost-based class ceiling,
20 by the target rate class ceiling or by the individual provider
21 target. The agency shall adjust the patient care component
22 effective January 1, 2002. The cost to adjust the direct care
23 subcomponent shall be net of the total funds previously
24 allocated for the case mix add-on. The agency shall make the
25 required changes to the nursing home cost reporting forms to
26 implement this requirement effective January 1, 2002.

27 3. The direct care subcomponent shall include salaries
28 and benefits of direct care staff providing nursing services
29 including registered nurses, licensed practical nurses, and
30 certified nursing assistants who deliver care directly to
31 residents in the nursing home facility. This excludes nursing

1 administration, MDS, and care plan coordinators, staff
2 development, and staffing coordinator.

3 4. All other patient care costs shall be included in
4 the indirect care cost subcomponent of the patient care per
5 diem rate. There shall be no costs directly or indirectly
6 allocated to the direct care subcomponent from a home office
7 or management company.

8 5. On July 1 of each year, the agency shall report to
9 the Legislature direct and indirect care costs, including
10 average direct and indirect care costs per resident per
11 facility and direct care and indirect care salaries and
12 benefits per category of staff member per facility.

13 6. Under the plan, interim rate adjustments shall not
14 be granted to reflect increases in the cost of general or
15 professional liability insurance for nursing homes unless the
16 following criteria are met: have at least a 65 percent
17 Medicaid utilization in the most recent cost report submitted
18 to the agency, and the increase in general or professional
19 liability costs to the facility for the most recent policy
20 period affects the total Medicaid per diem by at least 5
21 percent. This rate adjustment shall not result in the per diem
22 exceeding the class ceiling. This provision shall ~~apply only~~
23 to ~~fiscal year 2000-2001 and shall be implemented to the~~
24 extent existing appropriations are available. ~~The agency shall~~
25 report to the Governor, the Speaker of the House of
26 Representatives, and the President of the Senate by December
27 31, 2000, on the cost of liability insurance for Florida
28 nursing homes for fiscal years 1999 and 2000 and the extent to
29 which these costs are not being compensated by the Medicaid
30 program. Medicaid-participating nursing homes shall be
31 required to report to the agency information necessary to

1 ~~compile this report. Effective no earlier than the~~
2 ~~rate-setting period beginning April 1, 1999, the agency shall~~
3 ~~establish a case-mix reimbursement methodology for the rate of~~
4 ~~payment for long-term care services for nursing home~~
5 ~~residents. The agency shall compute a per diem rate for~~
6 ~~Medicaid residents, adjusted for case mix, which is based on a~~
7 ~~resident classification system that accounts for the relative~~
8 ~~resource utilization by different types of residents and which~~
9 ~~is based on level-of-care data and other appropriate data. The~~
10 ~~case-mix methodology developed by the agency shall take into~~
11 ~~account the medical, behavioral, and cognitive deficits of~~
12 ~~residents. In developing the reimbursement methodology, the~~
13 ~~agency shall evaluate and modify other aspects of the~~
14 ~~reimbursement plan as necessary to improve the overall~~
15 ~~effectiveness of the plan with respect to the costs of patient~~
16 ~~care, operating costs, and property costs. In the event~~
17 ~~adequate data are not available, the agency is authorized to~~
18 ~~adjust the patient's care component or the per diem rate to~~
19 ~~more adequately cover the cost of services provided in the~~
20 ~~patient's care component. The agency shall work with the~~
21 ~~Department of Elderly Affairs, the Florida Health Care~~
22 ~~Association, and the Florida Association of Homes for the~~
23 ~~Aging in developing the methodology.~~

24
25 It is the intent of the Legislature that the reimbursement
26 plan achieve the goal of providing access to health care for
27 nursing home residents who require large amounts of care while
28 encouraging diversion services as an alternative to nursing
29 home care for residents who can be served within the
30 community. The agency shall base the establishment of any
31 maximum rate of payment, whether overall or component, on the

1 available moneys as provided for in the General Appropriations
2 Act. The agency may base the maximum rate of payment on the
3 results of scientifically valid analysis and conclusions
4 derived from objective statistical data pertinent to the
5 particular maximum rate of payment.

6 (4) Subject to any limitations or directions provided
7 for in the General Appropriations Act, alternative health
8 plans, health maintenance organizations, and prepaid health
9 plans shall be reimbursed a fixed, prepaid amount negotiated,
10 or competitively bid pursuant to s. 287.057, by the agency and
11 prospectively paid to the provider monthly for each Medicaid
12 recipient enrolled. The amount may not exceed the average
13 amount the agency determines it would have paid, based on
14 claims experience, for recipients in the same or similar
15 category of eligibility. The agency shall calculate
16 capitation rates on a regional basis and, beginning September
17 1, 1995, shall include age-band differentials in such
18 calculations. Effective July 1, 2001, the cost of exempting
19 statutory teaching hospitals, specialty hospitals, and
20 community hospital education program hospitals from
21 reimbursement ceilings and the cost of special Medicaid
22 payments shall not be included in premiums paid to health
23 maintenance organizations or prepaid health care plans. Each
24 rate semester, the agency shall calculate and publish a
25 Medicaid hospital rate schedule that does not reflect either
26 special Medicaid payments or the elimination of rate
27 reimbursement ceilings, to be used by hospitals and Medicaid
28 health maintenance organizations, in order to determine the
29 Medicaid rate referred to in ss. 409.912(16), 409.9128(5), and
30 641.513(6).

31

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

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

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

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

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

27 (c) Medicaid will pay no portion of Medicare
28 deductibles and coinsurance when payment that Medicare has
29 made for the service equals or exceeds what Medicaid would
30 have paid if it had been the sole payor. The combined payment
31 of Medicare and Medicaid shall not exceed the amount Medicaid

1 would have paid had it been the sole payor. The Legislature
2 finds that there has been confusion regarding the
3 reimbursement for services rendered to dually eligible
4 Medicare beneficiaries. Accordingly, the Legislature clarifies
5 that it has always been the intent of the Legislature before
6 and after 1991 that, in reimbursing in accordance with fees
7 established by Title XVIII for premiums, deductibles, and
8 coinsurance for Medicare services rendered by physicians to
9 Medicaid eligible persons, physicians be reimbursed at the
10 lesser of the amount billed by the physician or the Medicaid
11 maximum allowable fee established by the Agency for Health
12 Care Administration, as is permitted by federal law. It has
13 never been the intent of the Legislature with regard to such
14 services rendered by physicians that Medicaid be required to
15 provide any payment for deductibles, coinsurance, or
16 copayments for Medicare cost sharing, or any expenses incurred
17 relating thereto, in excess of the payment amount provided for
18 under the State Medicaid plan for such service. This payment
19 methodology is applicable even in those situations in which
20 the payment for Medicare cost sharing for a qualified Medicare
21 beneficiary with respect to an item or service is reduced or
22 eliminated. This expression of the Legislature is in
23 clarification of existing law and shall apply to payment for,
24 and with respect to provider agreements with respect to, items
25 or services furnished on or after the effective date of this
26 act. This paragraph applies to payment by Medicaid for items
27 and services furnished before the effective date of this act
28 if such payment is the subject of a lawsuit that is based on
29 the provisions of this section, and that is pending as of, or
30 is initiated after, the effective date of this act.
31

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

3 1. Medicaid payments for Nursing Home Medicare part A
4 coinsurance shall be the lesser of the Medicare coinsurance
5 amount or the Medicaid nursing home per diem rate.

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

8 2.3. Medicaid shall pay all deductibles and
9 coinsurance for Medicare-eligible recipients receiving
10 freestanding end stage renal dialysis center services.

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

13 3.5. Medicaid payments for general hospital inpatient
14 services shall be limited to the Medicare deductible per spell
15 of illness. Medicaid shall make no payment toward coinsurance
16 for Medicare general hospital inpatient services.

17 4.6. Medicaid shall pay all deductibles and
18 coinsurance for Medicare emergency transportation services
19 provided by ambulances licensed pursuant to chapter 401.

20 (14) A provider of prescribed drugs shall be
21 reimbursed the least of the amount billed by the provider, the
22 provider's usual and customary charge, or the Medicaid maximum
23 allowable fee established by the agency, plus a dispensing
24 fee. The agency is directed to implement a variable dispensing
25 fee for payments for prescribed medicines while ensuring
26 continued access for Medicaid recipients. The variable
27 dispensing fee may be based upon, but not limited to, either
28 or both the volume of prescriptions dispensed by a specific
29 pharmacy provider and the volume of prescriptions dispensed to
30 an individual recipient. The agency is authorized to limit
31 reimbursement for prescribed medicine in order to comply with

1 any limitations or directions provided for in the General
2 Appropriations Act, which may include implementing a
3 prospective or concurrent utilization review program.

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

1 make other changes necessary to secure approval of federal
2 waivers needed to permit federal financing of Medicaid
3 transportation services at the service matching rate rather
4 than the administrative matching rate.

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

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

14 409.911 Disproportionate share program.--Subject to
15 specific allocations established within the General
16 Appropriations Act and any limitations established pursuant to
17 chapter 216, the agency shall distribute, pursuant to this
18 section, moneys to hospitals providing a disproportionate
19 share of Medicaid or charity care services by making quarterly
20 Medicaid payments as required. Notwithstanding the provisions
21 of s. 409.915, counties are exempt from contributing toward
22 the cost of this special reimbursement for hospitals serving a
23 disproportionate share of low-income patients.

24 (1) Definitions.--As used in this section and s.
25 409.9112:

26 (c) "Base Medicaid per diem" means the hospital's
27 Medicaid per diem rate initially established by the Agency for
28 Health Care Administration on January 1, 1999 ~~prior to the~~
29 ~~beginning of each state fiscal year~~. The base Medicaid per
30 diem rate shall not include any additional per diem increases
31

1 received as a result of the disproportionate share
2 distribution.

3 (3) In computing the disproportionate share rate:

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

8 ~~For fiscal year 1991-1992 and all years other than~~
9 ~~1992-1993,~~The following criteria shall be used in determining
10 the disproportionate share percentage:

11 (a) If the disproportionate share rate is less than 10
12 percent, the disproportionate share percentage is zero and
13 there is no additional payment.

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

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

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

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

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

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

1 (h) If the disproportionate share rate is greater than
2 or equal to 72.5 percent, then the disproportionate share
3 percentage is 170.

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

6 409.9116 Disproportionate share/financial assistance
7 program for rural hospitals.--In addition to the payments made
8 under s. 409.911, the Agency for Health Care Administration
9 shall administer a federally matched disproportionate share
10 program and a state-funded financial assistance program for
11 statutory rural hospitals. The agency shall make
12 disproportionate share payments to statutory rural hospitals
13 that qualify for such payments and financial assistance
14 payments to statutory rural hospitals that do not qualify for
15 disproportionate share payments. The disproportionate share
16 program payments shall be limited by and conform with federal
17 requirements. Funds shall be distributed quarterly in each
18 fiscal year for which an appropriation is made.

19 Notwithstanding the provisions of s. 409.915, counties are
20 exempt from contributing toward the cost of this special
21 reimbursement for hospitals serving a disproportionate share
22 of low-income patients.

23 (2) The agency shall use the following formula for
24 distribution of funds for the disproportionate share/financial
25 assistance program for rural hospitals.

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

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

1 Where:

2 PDAER = preliminary distribution amount for each rural
3 hospital.

4 TAERH = total amount earned by each rural hospital.

5 TARH = total amount appropriated or distributed under
6 this section.

7 STAERH = sum of total amount earned by each rural
8 hospital.

9 (b) Federal matching funds for the disproportionate
10 share program shall then be calculated for those hospitals
11 that qualify for disproportionate share in paragraph (a).

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

14
15 SFOER = Maximum value of (1) SFOL - PDAER or (2) 0
16

17 Where:

18 SFOER = state-funds-only payment amount for each rural
19 hospital.

20 SFOL = state-funds-only payment level, which is set at
21 4 percent of TARH.

22
23 In calculating the SFOER, PDAER includes federal matching
24 funds from paragraph (b).

25 (d) The adjusted total amount allocated to the rural
26 disproportionate share program shall then be calculated using
27 the following formula:

28
29 ATARH = (TARH - SSFOER)
30

31 Where:

1 ATARH = adjusted total amount appropriated or
 2 distributed under this section.

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

5 (e) The distribution of the adjusted total amount of
 6 rural disproportionate share hospital funds shall then be
 7 calculated using the following formula:

$$9 \qquad \qquad \qquad \text{DAERH} = [(TAERH \times ATARH) / STAERH]$$

11 Where:

12 DAERH = distribution amount for each rural hospital.

13 (f) Federal matching funds for the disproportionate
 14 share program shall then be calculated for those hospitals
 15 that qualify for disproportionate share in paragraph (e).

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

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

$$24 \qquad \qquad \qquad \text{DAER} = (TAERH \times TARH) / STAERH$$

26 ~~Where:~~

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

28 ~~STAERH = sum of total amount earned by each rural~~
 29 ~~hospital.~~

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

1 ~~TARH - total amount appropriated or distributed under~~
2 ~~this section.~~

3
4 ~~Federal matching funds for the disproportionate share program~~
5 ~~shall then be calculated for those hospitals that qualify for~~
6 ~~disproportionate share payments under this section.~~

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

9 409.91195 Medicaid Pharmaceutical and Therapeutics
10 Committee.--There is created a Medicaid Pharmaceutical and
11 Therapeutics Committee within the Agency for Health Care
12 Administration for the purpose of developing a preferred drug
13 formulary pursuant to 42 U.S.C. s. 1396r-8. ~~The committee~~
14 ~~shall develop and implement a voluntary Medicaid preferred~~
15 ~~prescribed drug designation program. The program shall provide~~
16 ~~information to Medicaid providers on medically appropriate and~~
17 ~~cost-efficient prescription drug therapies through the~~
18 ~~development and publication of a voluntary Medicaid preferred~~
19 ~~prescribed drug list.~~

20 (1) The Medicaid Pharmaceutical and Therapeutics
21 Committee shall be comprised as specified in 42 U.S.C. s.
22 1396r-8 and consist of eleven members appointed by the
23 Governor. Four members shall be physicians, licensed under
24 chapter 458; one member licensed under chapter 459; five
25 members shall be pharmacists licensed under chapter 465; and
26 one member shall be a consumer representative. ~~of nine members~~
27 ~~appointed as follows: one practicing physician licensed under~~
28 ~~chapter 458, appointed by the Speaker of the House of~~
29 ~~Representatives from a list of recommendations from the~~
30 ~~Florida Medical Association; one practicing physician licensed~~
31 ~~under chapter 459, appointed by the Speaker of the House of~~

1 ~~Representatives from a list of recommendations from the~~
2 ~~Florida Osteopathic Medical Association; one practicing~~
3 ~~physician licensed under chapter 458, appointed by the~~
4 ~~President of the Senate from a list of recommendations from~~
5 ~~the Florida Academy of Family Physicians; one practicing~~
6 ~~podiatric physician licensed under chapter 461, appointed by~~
7 ~~the President of the Senate from a list of recommendations~~
8 ~~from the Florida Podiatric Medical Association; one trauma~~
9 ~~surgeon licensed under chapter 458, appointed by the Speaker~~
10 ~~of the House of Representatives from a list of recommendations~~
11 ~~from the American College of Surgeons; one practicing dentist~~
12 ~~licensed under chapter 466, appointed by the President of the~~
13 ~~Senate from a list of recommendations from the Florida Dental~~
14 ~~Association; one practicing pharmacist licensed under chapter~~
15 ~~465, appointed by the Governor from a list of recommendations~~
16 ~~from the Florida Pharmacy Association; one practicing~~
17 ~~pharmacist licensed under chapter 465, appointed by the~~
18 ~~Governor from a list of recommendations from the Florida~~
19 ~~Society of Health System Pharmacists; and one health care~~
20 ~~professional with expertise in clinical pharmacology appointed~~
21 ~~by the Governor from a list of recommendations from the~~
22 ~~Pharmaceutical Research and Manufacturers Association. The~~
23 ~~members shall be appointed to serve for terms of 2 years from~~
24 ~~the date of their appointment. Members may be appointed to~~
25 ~~more than one term. The Agency for Health Care Administration~~
26 ~~shall serve as staff for the committee and assist them with~~
27 ~~all ministerial duties. The Governor shall ensure that at~~
28 ~~least some of the members of the Medicaid Pharmaceutical and~~
29 ~~Therapeutics Committee represent Medicaid participating~~
30 ~~physicians and pharmacies serving all segments and diversity~~
31 ~~of the Medicaid population, and have experience in either~~

1 developing or practicing under a preferred drug formulary. At
2 least one of the members shall represent the interests of
3 pharmaceutical manufacturers.

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

6 (3) The committee shall meet at least quarterly and
7 may meet at other times at the discretion of the chairperson
8 and members. The committee shall comply with rules adopted by
9 the agency, including notice of any meeting of the committee
10 pursuant to the requirements of the Administrative Procedure
11 Act.

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

18 ~~(2) Upon recommendation by the committee, the Agency~~
19 ~~for Health Care Administration shall establish the voluntary~~
20 ~~Medicaid preferred prescribed drug list. Upon further~~
21 ~~recommendation by the committee, the agency shall add to,~~
22 ~~delete from, or modify the list. The committee shall also~~
23 ~~review requests for additions to, deletions from, or~~
24 ~~modifications of the list. The list shall be adopted by the~~
25 ~~committee in consultation with medical specialists, when~~
26 ~~appropriate, using the following criteria: use of the list~~
27 ~~shall be voluntary by providers and the list must provide for~~
28 ~~medically appropriate drug therapies for Medicaid patients~~
29 ~~which achieve cost savings contained in the General~~
30 ~~Appropriations Act.~~

31

1 (5) Except for mental health-related drugs,
2 anti-retroviral drugs, and drugs for nursing home residents
3 and other institutional residents, reimbursement of drugs not
4 included in the formulary is subject to prior authorization in
5 the Medicaid program.

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

10 (7) The committee shall ensure that pharmaceutical
11 manufacturers agreeing to provide a supplemental rebate as
12 outlined in this chapter have an opportunity to present
13 evidence supporting inclusion of a product on the preferred
14 drug list. Upon timely notice, the agency shall ensure that
15 any drug that has been approved or had any of its particular
16 uses approved by the United States Food and Drug
17 Administration under a priority review classification will be
18 reviewed by the Medicaid Pharmaceutical and Therapeutics
19 Committee at the next regularly scheduled meeting. To the
20 extent possible, upon notice by a manufacturer the agency
21 shall also schedule a product review for any new product at
22 the next regularly scheduled Medicaid Pharmaceutical and
23 Therapeutics Committee.

24 (8) Until the Medicaid Pharmaceutical and Therapeutics
25 Committee is appointed and a preferred drug list adopted by
26 the agency, the agency shall use the existing voluntary
27 preferred drug list adopted pursuant to Chapter 2000-367,
28 Section 72, Laws of Florida. Drugs not listed on the voluntary
29 preferred drug list will require prior authorization by the
30 agency or its contractor.

31

1 (9) The Medicaid Pharmaceutical and Therapeutics
2 Committee shall develop its preferred drug list
3 recommendations by considering the clinical efficacy, safety,
4 and cost effectiveness of a product. When the preferred drug
5 formulary is adopted by the agency, if a product on the
6 formulary is one of the first four brand-name drugs used by a
7 recipient in a month the drug shall not require prior
8 authorization.

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

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

17 Section 9. Section 409.912, Florida Statutes, is
18 amended to read:

19 409.912 Cost-effective purchasing of health care.--The
20 agency shall purchase goods and services for Medicaid
21 recipients in the most cost-effective manner consistent with
22 the delivery of quality medical care. The agency shall
23 maximize the use of prepaid per capita and prepaid aggregate
24 fixed-sum basis services when appropriate and other
25 alternative service delivery and reimbursement methodologies,
26 including competitive bidding pursuant to s. 287.057, designed
27 to facilitate the cost-effective purchase of a case-managed
28 continuum of care. The agency shall also require providers to
29 minimize the exposure of recipients to the need for acute
30 inpatient, custodial, and other institutional care and the
31 inappropriate or unnecessary use of high-cost services. The

1 agency may establish prior authorization requirements for
2 certain populations of Medicaid beneficiaries, certain drug
3 classes, or particular drugs to prevent fraud, abuse, overuse,
4 and possible dangerous drug interactions. The Pharmaceutical
5 and Therapeutics Committee shall make recommendations to the
6 agency on drugs for which prior authorization is required. The
7 agency shall inform the Pharmaceutical and Therapeutics
8 Committee of its decisions regarding drugs subject to prior
9 authorization.

10 (1) The agency may enter into agreements with
11 appropriate agents of other state agencies or of any agency of
12 the Federal Government and accept such duties in respect to
13 social welfare or public aid as may be necessary to implement
14 the provisions of Title XIX of the Social Security Act and ss.
15 409.901-409.920.

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

19 (3) The agency may contract with:

20 (a) An entity that provides no prepaid health care
21 services other than Medicaid services under contract with the
22 agency and which is owned and operated by a county, county
23 health department, or county-owned and operated hospital to
24 provide health care services on a prepaid or fixed-sum basis
25 to recipients, which entity may provide such prepaid services
26 either directly or through arrangements with other providers.
27 Such prepaid health care services entities must be licensed
28 under parts I and III by January 1, 1998, and until then are
29 exempt from the provisions of part I of chapter 641. An entity
30 recognized under this paragraph which demonstrates to the
31 satisfaction of the Department of Insurance that it is backed

1 by the full faith and credit of the county in which it is
2 located may be exempted from s. 641.225.

3 (b) An entity that is providing comprehensive
4 behavioral health care services to certain Medicaid recipients
5 through a capitated, prepaid arrangement pursuant to the
6 federal waiver provided for by s. 409.905(5). Such an entity
7 must be licensed under chapter 624, chapter 636, or chapter
8 641 and must possess the clinical systems and operational
9 competence to manage risk and provide comprehensive behavioral
10 health care to Medicaid recipients. As used in this paragraph,
11 the term "comprehensive behavioral health care services" means
12 covered mental health and substance abuse treatment services
13 that are available to Medicaid recipients. The secretary of
14 the Department of Children and Family Services shall approve
15 provisions of procurements related to children in the
16 department's care or custody prior to enrolling such children
17 in a prepaid behavioral health plan. Any contract awarded
18 under this paragraph must be competitively procured. In
19 developing the behavioral health care prepaid plan procurement
20 document, the agency shall ensure that the procurement
21 document requires the contractor to develop and implement a
22 plan to ensure compliance with s. 394.4574 related to services
23 provided to residents of licensed assisted living facilities
24 that hold a limited mental health license. The agency must
25 ensure that Medicaid recipients have available the choice of
26 at least two managed care plans for their behavioral health
27 care services. The agency may reimburse for
28 substance-abuse-treatment services on a fee-for-service basis
29 until the agency finds that adequate funds are available for
30 capitated, prepaid arrangements.

31

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

6 2. By December 31, 2001, the agency shall contract
7 with entities providing comprehensive behavioral health care
8 services to Medicaid recipients through capitated, prepaid
9 arrangements in Charlotte, Collier, DeSoto, Escambia, Glades,
10 Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota,
11 and Walton Counties. The agency may contract with entities
12 providing comprehensive behavioral health care services to
13 Medicaid recipients through capitated, prepaid arrangements in
14 Alachua County. The agency may determine if Sarasota County
15 shall be included as a separate catchment area or included in
16 any other agency geographic area.

17 3. Children residing in a Department of Juvenile
18 Justice residential program approved as a Medicaid behavioral
19 health overlay services provider shall not be included in a
20 behavioral health care prepaid health plan pursuant to this
21 paragraph.

22 4. In converting to a prepaid system of delivery, the
23 agency shall in its procurement document require an entity
24 providing comprehensive behavioral health care services to
25 prevent the displacement of indigent care patients by
26 enrollees in the Medicaid prepaid health plan providing
27 behavioral health care services from facilities receiving
28 state funding to provide indigent behavioral health care, to
29 facilities licensed under chapter 395 which do not receive
30 state funding for indigent behavioral health care, or
31

1 reimburse the unsubsidized facility for the cost of behavioral
2 health care provided to the displaced indigent care patient.

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

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

21 (d) No more than four provider service networks for
22 demonstration projects to test Medicaid direct contracting.
23 The demonstration projects may be reimbursed on a
24 fee-for-service or prepaid basis. A provider service network
25 which is reimbursed by the agency on a prepaid basis shall be
26 exempt from parts I and III of chapter 641, but must meet
27 appropriate financial reserve, quality assurance, and patient
28 rights requirements as established by the agency. The agency
29 shall award contracts on a competitive bid basis and shall
30 select bidders based upon price and quality of care. Medicaid
31 recipients assigned to a demonstration project shall be chosen

1 equally from those who would otherwise have been assigned to
2 prepaid plans and MediPass. The agency is authorized to seek
3 federal Medicaid waivers as necessary to implement the
4 provisions of this section. A demonstration project awarded
5 pursuant to this paragraph shall be for 4 ~~2~~ years from the
6 date of implementation.

7 (e) An entity that provides comprehensive behavioral
8 health care services to certain Medicaid recipients through an
9 administrative services organization agreement. Such an entity
10 must possess the clinical systems and operational competence
11 to provide comprehensive health care to Medicaid recipients.
12 As used in this paragraph, the term "comprehensive behavioral
13 health care services" means covered mental health and
14 substance abuse treatment services that are available to
15 Medicaid recipients. Any contract awarded under this paragraph
16 must be competitively procured. The agency must ensure that
17 Medicaid recipients have available the choice of at least two
18 managed care plans for their behavioral health care services.

19 (f) An entity in Pasco County or Pinellas County that
20 provides in-home physician services to Medicaid recipients
21 with degenerative neurological diseases in order to test the
22 cost-effectiveness of enhanced home-based medical care. The
23 entity providing the services shall be reimbursed on a
24 fee-for-service basis at a rate not less than comparable
25 Medicare reimbursement rates. The agency may apply for waivers
26 of federal regulations necessary to implement such program.
27 This paragraph shall be repealed on July 1, 2002.

28 (g) Children's provider networks that provide care
29 coordination and care management for Medicaid-eligible
30 pediatric patients, primary care, authorization of specialty
31 care, and other urgent and emergency care through organized

1 providers designed to service Medicaid eligibles under age 18.
2 The networks shall provide after-hour operations, including
3 evening and weekend hours, to promote, when appropriate, the
4 use of the children's networks rather than hospital emergency
5 departments.

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

12 (a) Is organized primarily for the purpose of
13 providing health care or other services of the type regularly
14 offered to Medicaid recipients;

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

17 (c) Makes provisions satisfactory to the agency for
18 insolvency protection and ensures that neither enrolled
19 Medicaid recipients nor the agency will be liable for the
20 debts of the entity;

21 (d) Submits to the agency, if a private entity, a
22 financial plan that the agency finds to be fiscally sound and
23 that provides for working capital in the form of cash or
24 equivalent liquid assets excluding revenues from Medicaid
25 premium payments equal to at least the first 3 months of
26 operating expenses or \$200,000, whichever is greater;

27 (e) Furnishes evidence satisfactory to the agency of
28 adequate liability insurance coverage or an adequate plan of
29 self-insurance to respond to claims for injuries arising out
30 of the furnishing of health care;

31

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

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

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

8 (a) Pays for health care services provided to enrolled
9 Medicaid recipients in exchange for a premium payment paid by
10 the agency;

11 (b) Assumes the underwriting risk; and

12 (c) Is organized and licensed under applicable
13 provisions of the Florida Insurance Code and is currently in
14 good standing with the Department of Insurance.

15 (6) The agency may contract on a prepaid or fixed-sum
16 basis with an exclusive provider organization to provide
17 health care services to Medicaid recipients provided that ~~the~~
18 ~~contract does not cost more than a managed care plan contract~~
19 ~~in the same agency region and that~~ the exclusive provider
20 organization meets applicable managed care plan requirements
21 in this section, ss. 409.9122, 409.9123, 409.9128, and
22 627.6472, and other applicable provisions of law.

23 (7) The Agency for Health Care Administration may
24 provide cost-effective purchasing of chiropractic services on
25 a fee-for-service basis to Medicaid recipients through
26 arrangements with a statewide chiropractic preferred provider
27 organization incorporated in this state as a not-for-profit
28 corporation. The agency shall ensure that the benefit limits
29 and prior authorization requirements in the current Medicaid
30 program shall apply to the services provided by the
31 chiropractic preferred provider organization.

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

9 (a) Fraud;

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

13 (c) Commission of a felony involving embezzlement,
14 theft, forgery, income tax evasion, bribery, falsification or
15 destruction of records, making false statements, receiving
16 stolen property, making false claims, or obstruction of
17 justice; or

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

21 (9) The agency, after notifying the Legislature, may
22 apply for waivers of applicable federal laws and regulations
23 as necessary to implement more appropriate systems of health
24 care for Medicaid recipients and reduce the cost of the
25 Medicaid program to the state and federal governments and
26 shall implement such programs, after legislative approval,
27 within a reasonable period of time after federal approval.
28 These programs must be designed primarily to reduce the need
29 for inpatient care, custodial care and other long-term or
30 institutional care, and other high-cost services.

31

1 (a) Prior to seeking legislative approval of such a
2 waiver as authorized by this subsection, the agency shall
3 provide notice and an opportunity for public comment. Notice
4 shall be provided to all persons who have made requests of the
5 agency for advance notice and shall be published in the
6 Florida Administrative Weekly not less than 28 days prior to
7 the intended action.

8 (b) Notwithstanding s. 216.292, funds that are
9 appropriated to the Department of Elderly Affairs for the
10 Assisted Living for the Elderly Medicaid waiver and are not
11 expended shall be transferred to the agency to fund
12 Medicaid-reimbursed nursing home care.

13 (10) The agency shall establish a postpayment
14 utilization control program designed to identify recipients
15 who may inappropriately overuse or underuse Medicaid services
16 and shall provide methods to correct such misuse.

17 (11) The agency shall develop and provide coordinated
18 systems of care for Medicaid recipients and may contract with
19 public or private entities to develop and administer such
20 systems of care among public and private health care providers
21 in a given geographic area.

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

25 (13)(a) The agency shall identify health care
26 utilization and price patterns within the Medicaid program
27 which are not cost-effective or medically appropriate and
28 assess the effectiveness of new or alternate methods of
29 providing and monitoring service, and may implement such
30 methods as it considers appropriate. Such methods may include
31 disease management initiatives, an integrated and systematic

1 approach for managing the health care needs of recipients who
2 are at risk of or diagnosed with a specific disease by using
3 best practices, prevention strategies, clinical-practice
4 improvement, clinical interventions and protocols, outcomes
5 research, information technology, and other tools and
6 resources to reduce overall costs and improve measurable
7 outcomes.

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

15 1. The practice pattern identification program shall
16 evaluate practitioner prescribing patterns based on national
17 and regional practice guidelines, comparing practitioners to
18 their peer groups. The agency and its Drug Utilization Review
19 Board shall consult with a panel of practicing health care
20 professionals consisting of the following: the Speaker of the
21 House of Representatives and the President of the Senate shall
22 each appoint three physicians licensed under chapter 458 or
23 chapter 459; and the Governor shall appoint two pharmacists
24 licensed under chapter 465 and one dentist licensed under
25 chapter 466 who is an oral surgeon. Terms of the panel members
26 shall expire at the discretion of the appointing official. The
27 panel shall begin its work by August 1, 1999, regardless of
28 the number of appointments made by that date. The advisory
29 panel shall be responsible for evaluating treatment guidelines
30 and recommending ways to incorporate their use in the practice
31 pattern identification program. Practitioners who are

1 prescribing inappropriately or inefficiently, as determined by
2 the agency, may have their prescribing of certain drugs
3 subject to prior authorization.

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

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

16 4. The agency may apply for any federal waivers needed
17 to implement this paragraph.

18 (14) An entity contracting on a prepaid or fixed-sum
19 basis shall, in addition to meeting any applicable statutory
20 surplus requirements, also maintain at all times in the form
21 of cash, investments that mature in less than 180 days
22 allowable as admitted assets by the Department of Insurance,
23 and restricted funds or deposits controlled by the agency or
24 the Department of Insurance, a surplus amount equal to
25 one-and-one-half times the entity's monthly Medicaid prepaid
26 revenues. As used in this subsection, the term "surplus" means
27 the entity's total assets minus total liabilities. If an
28 entity's surplus falls below an amount equal to
29 one-and-one-half times the entity's monthly Medicaid prepaid
30 revenues, the agency shall prohibit the entity from engaging
31 in marketing and preenrollment activities, shall cease to

1 process new enrollments, and shall not renew the entity's
2 contract until the required balance is achieved. The
3 requirements of this subsection do not apply:

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

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

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

10 2. Submits a written guarantee acceptable to the
11 agency which is irrevocable during the term of the contracting
12 entity's contract with the agency and, upon termination of the
13 contract, until the agency receives proof of satisfaction of
14 all outstanding obligations incurred under the contract.

15 (15)(a) The agency may require an entity contracting
16 on a prepaid or fixed-sum basis to establish a restricted
17 insolvency protection account with a federally guaranteed
18 financial institution licensed to do business in this state.
19 The entity shall deposit into that account 5 percent of the
20 capitation payments made by the agency each month until a
21 maximum total of 2 percent of the total current contract
22 amount is reached. The restricted insolvency protection
23 account may be drawn upon with the authorized signatures of
24 two persons designated by the entity and two representatives
25 of the agency. If the agency finds that the entity is
26 insolvent, the agency may draw upon the account solely with
27 the two authorized signatures of representatives of the
28 agency, and the funds may be disbursed to meet financial
29 obligations incurred by the entity under the prepaid contract.
30 If the contract is terminated, expired, or not continued, the
31 account balance must be released by the agency to the entity

1 upon receipt of proof of satisfaction of all outstanding
2 obligations incurred under this contract.

3 (b) The agency may waive the insolvency protection
4 account requirement in writing when evidence is on file with
5 the agency of adequate insolvency insurance and reinsurance
6 that will protect enrollees if the entity becomes unable to
7 meet its obligations.

8 (16) An entity that contracts with the agency on a
9 prepaid or fixed-sum basis for the provision of Medicaid
10 services shall reimburse any hospital or physician that is
11 outside the entity's authorized geographic service area as
12 specified in its contract with the agency, and that provides
13 services authorized by the entity to its members, at a rate
14 negotiated with the hospital or physician for the provision of
15 services or according to the lesser of the following:

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

18 (b) The Florida Medicaid reimbursement rate
19 established for the hospital or physician.

20 (17) When a merger or acquisition of a Medicaid
21 prepaid contractor has been approved by the Department of
22 Insurance pursuant to s. 628.4615, the agency shall approve
23 the assignment or transfer of the appropriate Medicaid prepaid
24 contract upon request of the surviving entity of the merger or
25 acquisition if the contractor and the other entity have been
26 in good standing with the agency for the most recent 12-month
27 period, unless the agency determines that the assignment or
28 transfer would be detrimental to the Medicaid recipients or
29 the Medicaid program. To be in good standing, an entity must
30 not have failed accreditation or committed any material
31 violation of the requirements of s. 641.52 and must meet the

1 Medicaid contract requirements. For purposes of this section,
2 a merger or acquisition means a change in controlling interest
3 of an entity, including an asset or stock purchase.

4 (18) Any entity contracting with the agency pursuant
5 to this section to provide health care services to Medicaid
6 recipients is prohibited from engaging in any of the following
7 practices or activities:

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

11 (b) Activities that could mislead or confuse
12 recipients, or misrepresent the organization, its marketing
13 representatives, or the agency. Violations of this paragraph
14 include, but are not limited to:

15 1. False or misleading claims that marketing
16 representatives are employees or representatives of the state
17 or county, or of anyone other than the entity or the
18 organization by whom they are reimbursed.

19 2. False or misleading claims that the entity is
20 recommended or endorsed by any state or county agency, or by
21 any other organization which has not certified its endorsement
22 in writing to the entity.

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

25 4. Claims that a Medicaid recipient will lose benefits
26 under the Medicaid program, or any other health or welfare
27 benefits to which the recipient is legally entitled, if the
28 recipient does not enroll with the entity.

29 (c) Granting or offering of any monetary or other
30 valuable consideration for enrollment, except as authorized by
31 subsection (21).

1 (d) Door-to-door solicitation of recipients who have
2 not contacted the entity or who have not invited the entity to
3 make a presentation.

4 (e) Solicitation of Medicaid recipients by marketing
5 representatives stationed in state offices unless approved and
6 supervised by the agency or its agent and approved by the
7 affected state agency when solicitation occurs in an office of
8 the state agency. The agency shall ensure that marketing
9 representatives stationed in state offices shall market their
10 managed care plans to Medicaid recipients only in designated
11 areas and in such a way as to not interfere with the
12 recipients' activities in the state office.

13 (f) Enrollment of Medicaid recipients.

14 (19) The agency may impose a fine for a violation of
15 this section or the contract with the agency by a person or
16 entity that is under contract with the agency. With respect
17 to any nonwillful violation, such fine shall not exceed \$2,500
18 per violation. In no event shall such fine exceed an
19 aggregate amount of \$10,000 for all nonwillful violations
20 arising out of the same action. With respect to any knowing
21 and willful violation of this section or the contract with the
22 agency, the agency may impose a fine upon the entity in an
23 amount not to exceed \$20,000 for each such violation. In no
24 event shall such fine exceed an aggregate amount of \$100,000
25 for all knowing and willful violations arising out of the same
26 action.

27 (20) A health maintenance organization or a person or
28 entity exempt from chapter 641 that is under contract with the
29 agency for the provision of health care services to Medicaid
30 recipients may not use or distribute marketing materials used
31 to solicit Medicaid recipients, unless such materials have

1 | been approved by the agency. The provisions of this subsection
2 | do not apply to general advertising and marketing materials
3 | used by a health maintenance organization to solicit both
4 | non-Medicaid subscribers and Medicaid recipients.

5 | (21) Upon approval by the agency, health maintenance
6 | organizations and persons or entities exempt from chapter 641
7 | that are under contract with the agency for the provision of
8 | health care services to Medicaid recipients may be permitted
9 | within the capitation rate to provide additional health
10 | benefits that the agency has found are of high quality, are
11 | practicably available, provide reasonable value to the
12 | recipient, and are provided at no additional cost to the
13 | state.

14 | (22) The agency shall utilize the statewide health
15 | maintenance organization complaint hotline for the purpose of
16 | investigating and resolving Medicaid and prepaid health plan
17 | complaints, maintaining a record of complaints and confirmed
18 | problems, and receiving disenrollment requests made by
19 | recipients.

20 | (23) The agency shall require the publication of the
21 | health maintenance organization's and the prepaid health
22 | plan's consumer services telephone numbers and the "800"
23 | telephone number of the statewide health maintenance
24 | organization complaint hotline on each Medicaid identification
25 | card issued by a health maintenance organization or prepaid
26 | health plan contracting with the agency to serve Medicaid
27 | recipients and on each subscriber handbook issued to a
28 | Medicaid recipient.

29 | (24) The agency shall establish a health care quality
30 | improvement system for those entities contracting with the
31 | agency pursuant to this section, incorporating all the

1 standards and guidelines developed by the Medicaid Bureau of
2 the Health Care Financing Administration as a part of the
3 quality assurance reform initiative. The system shall
4 include, but need not be limited to, the following:

5 (a) Guidelines for internal quality assurance
6 programs, including standards for:

7 1. Written quality assurance program descriptions.

8 2. Responsibilities of the governing body for
9 monitoring, evaluating, and making improvements to care.

10 3. An active quality assurance committee.

11 4. Quality assurance program supervision.

12 5. Requiring the program to have adequate resources to
13 effectively carry out its specified activities.

14 6. Provider participation in the quality assurance
15 program.

16 7. Delegation of quality assurance program activities.

17 8. Credentialing and recredentialing.

18 9. Enrollee rights and responsibilities.

19 10. Availability and accessibility to services and
20 care.

21 11. Ambulatory care facilities.

22 12. Accessibility and availability of medical records,
23 as well as proper recordkeeping and process for record review.

24 13. Utilization review.

25 14. A continuity of care system.

26 15. Quality assurance program documentation.

27 16. Coordination of quality assurance activity with
28 other management activity.

29 17. Delivering care to pregnant women and infants; to
30 elderly and disabled recipients, especially those who are at
31 risk of institutional placement; to persons with developmental

1 disabilities; and to adults who have chronic, high-cost
2 medical conditions.

3 (b) Guidelines which require the entities to conduct
4 quality-of-care studies which:

5 1. Target specific conditions and specific health
6 service delivery issues for focused monitoring and evaluation.

7 2. Use clinical care standards or practice guidelines
8 to objectively evaluate the care the entity delivers or fails
9 to deliver for the targeted clinical conditions and health
10 services delivery issues.

11 3. Use quality indicators derived from the clinical
12 care standards or practice guidelines to screen and monitor
13 care and services delivered.

14 (c) Guidelines for external quality review of each
15 contractor which require: focused studies of patterns of care;
16 individual care review in specific situations; and followup
17 activities on previous pattern-of-care study findings and
18 individual-care-review findings. In designing the external
19 quality review function and determining how it is to operate
20 as part of the state's overall quality improvement system, the
21 agency shall construct its external quality review
22 organization and entity contracts to address each of the
23 following:

24 1. Delineating the role of the external quality review
25 organization.

26 2. Length of the external quality review organization
27 contract with the state.

28 3. Participation of the contracting entities in
29 designing external quality review organization review
30 activities.

31

1 4. Potential variation in the type of clinical
2 conditions and health services delivery issues to be studied
3 at each plan.

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

6 6. Methods for implementing focused studies.

7 7. Individual care review.

8 8. Followup activities.

9 (25) In order to ensure that children receive health
10 care services for which an entity has already been
11 compensated, an entity contracting with the agency pursuant to
12 this section shall achieve an annual Early and Periodic
13 Screening, Diagnosis, and Treatment (EPSDT) Service screening
14 rate of at least 60 percent for those recipients continuously
15 enrolled for at least 8 months. The agency shall develop a
16 method by which the EPSDT screening rate shall be calculated.
17 For any entity which does not achieve the annual 60 percent
18 rate, the entity must submit a corrective action plan for the
19 agency's approval. If the entity does not meet the standard
20 established in the corrective action plan during the specified
21 timeframe, the agency is authorized to impose appropriate
22 contract sanctions. At least annually, the agency shall
23 publicly release the EPSDT Services screening rates of each
24 entity it has contracted with on a prepaid basis to serve
25 Medicaid recipients.

26 (26) The agency shall perform choice counseling,
27 enrollments, and disenrollments for Medicaid recipients who
28 are eligible for MediPass or managed care plans.
29 Notwithstanding the prohibition contained in paragraph
30 (18)(f), managed care plans may perform reenrollments of
31 Medicaid recipients under the supervision of the agency or its

1 agents. For the purposes of this section, "preenrollment"
2 means the provision of marketing and educational materials to
3 a Medicaid recipient and assistance in completing the
4 application forms, but shall not include actual enrollment
5 into a managed care plan. An application for enrollment shall
6 not be deemed complete until the agency or its agent verifies
7 that the recipient made an informed, voluntary choice. The
8 agency, in cooperation with the Department of Children and
9 Family Services, may test new marketing initiatives to inform
10 Medicaid recipients about their managed care options at
11 selected sites. The agency shall report to the Legislature on
12 the effectiveness of such initiatives. The agency may
13 contract with a third party to perform managed care plan and
14 MediPass choice-counseling, enrollment, and disenrollment
15 services for Medicaid recipients and is authorized to adopt
16 rules to implement such services. The agency may adjust the
17 capitation rate only to cover the costs of a third-party
18 choice-counseling, enrollment, and disenrollment contract, and
19 for agency supervision and management of the managed care plan
20 choice-counseling, enrollment, and disenrollment contract.

21 (27) Any lists of providers made available to Medicaid
22 recipients, MediPass enrollees, or managed care plan enrollees
23 shall be arranged alphabetically showing the provider's name
24 and specialty and, separately, by specialty in alphabetical
25 order.

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

29 (a) At least quarterly analysis and followup,
30 including sanctions as appropriate, of managed care
31 participant utilization of services.

1 (b) At least quarterly analysis and followup,
2 including sanctions as appropriate, of quality findings of the
3 Medicaid peer review organization and other external quality
4 assurance programs.

5 (c) At least quarterly analysis and followup,
6 including sanctions as appropriate, of the fiscal viability of
7 managed care plans.

8 (d) At least quarterly analysis and followup,
9 including sanctions as appropriate, of managed care
10 participant satisfaction and disenrollment surveys.

11 (e) The agency shall conduct regular and ongoing
12 Medicaid recipient satisfaction surveys.

13

14 The analyses and followup activities conducted by the agency
15 under its enhanced managed care quality assurance oversight
16 function shall not duplicate the activities of accreditation
17 reviewers for entities regulated under part III of chapter
18 641, but may include a review of the finding of such
19 reviewers.

20 (29) Each managed care plan that is under contract
21 with the agency to provide health care services to Medicaid
22 recipients shall annually conduct a background check with the
23 Florida Department of Law Enforcement of all persons with
24 ownership interest of 5 percent or more or executive
25 management responsibility for the managed care plan and shall
26 submit to the agency information concerning any such person
27 who has been found guilty of, regardless of adjudication, or
28 has entered a plea of nolo contendere or guilty to, any of the
29 offenses listed in s. 435.03.

30 (30) The agency shall, by rule, develop a process
31 whereby a Medicaid managed care plan enrollee who wishes to

1 enter hospice care may be disenrolled from the managed care
2 plan within 24 hours after contacting the agency regarding
3 such request. The agency rule shall include a methodology for
4 the agency to recoup managed care plan payments on a pro rata
5 basis if payment has been made for the enrollment month when
6 disenrollment occurs.

7 (31) The agency and entities which contract with the
8 agency to provide health care services to Medicaid recipients
9 under this section or s. 409.9122 must comply with the
10 provisions of s. 641.513 in providing emergency services and
11 care to Medicaid recipients and MediPass recipients.

12 (32) All entities providing health care services to
13 Medicaid recipients shall make available, and encourage all
14 pregnant women and mothers with infants to receive, and
15 provide documentation in the medical records to reflect, the
16 following:

17 (a) Healthy Start prenatal or infant screening.

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

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

22 (d) Immunizations in accordance with recommendations
23 of the Advisory Committee on Immunization Practices of the
24 United States Public Health Service and the American Academy
25 of Pediatrics, as appropriate.

26 (e) Counseling and services for family planning to all
27 women and their partners.

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

31

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

3 (33) Any entity that provides Medicaid prepaid health
4 plan services shall ensure the appropriate coordination of
5 health care services with an assisted living facility in cases
6 where a Medicaid recipient is both a member of the entity's
7 prepaid health plan and a resident of the assisted living
8 facility. If the entity is at risk for Medicaid targeted case
9 management and behavioral health services, the entity shall
10 inform the assisted living facility of the procedures to
11 follow should an emergent condition arise.

12 (34) The agency may seek and implement federal waivers
13 necessary to provide for cost-effective purchasing of home
14 health services, private duty nursing services,
15 transportation, independent laboratory services, and durable
16 medical equipment and supplies through competitive bidding
17 ~~negotiation~~ pursuant to s. 287.057. The agency may request
18 appropriate waivers from the federal Health Care Financing
19 Administration in order to competitively bid such home health
20 services. The agency may exclude providers not selected
21 through the bidding process from the Medicaid provider
22 network.

23 (35) The Agency for Health Care Administration is
24 directed to issue a request for proposal or intent to
25 negotiate to implement on a demonstration basis an outpatient
26 specialty services pilot project in a rural and urban county
27 in the state. As used in this subsection, the term
28 "outpatient specialty services" means clinical laboratory,
29 diagnostic imaging, and specified home medical services to
30 include durable medical equipment, prosthetics and orthotics,
31 and infusion therapy.

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

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

6 2. The entity must be experienced in providing
7 outpatient specialty services.

8 3. The entity must demonstrate to the satisfaction of
9 the agency that it provides high-quality services to its
10 patients.

11 4. The entity must demonstrate that it has in place a
12 complaints and grievance process to assist Medicaid recipients
13 enrolled in the pilot managed care program to resolve
14 complaints and grievances.

15 (b) The pilot managed care program shall operate for a
16 period of 3 years. The objective of the pilot program shall
17 be to determine the cost-effectiveness and effects on
18 utilization, access, and quality of providing outpatient
19 specialty services to Medicaid recipients on a prepaid,
20 capitated basis.

21 (c) The agency shall conduct a quality assurance
22 review of the prepaid health clinic each year that the
23 demonstration program is in effect. The prepaid health clinic
24 is responsible for all expenses incurred by the agency in
25 conducting a quality assurance review.

26 (d) The entity that is awarded the contract to provide
27 outpatient specialty services to Medicaid recipients shall
28 report data required by the agency in a format specified by
29 the agency, for the purpose of conducting the evaluation
30 required in paragraph (e).

31

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

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

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

10 1. Medicaid prescribed-drug coverage for brand-name
11 drugs for adult Medicaid recipients ~~not residing in nursing~~
12 ~~homes or other institutions~~ is limited to the dispensing of
13 four brand-name drugs per month per recipient. Children ~~and~~
14 ~~institutionalized adults~~ are exempt from this restriction.
15 Antiretroviral agents are excluded from this limitation. No
16 requirements for prior authorization or other restrictions on
17 medications used to treat mental illnesses such as
18 schizophrenia, severe depression, or bipolar disorder may be
19 imposed on Medicaid recipients. Medications that will be
20 available without restriction for persons with mental
21 illnesses include atypical antipsychotic medications,
22 conventional antipsychotic medications, selective serotonin
23 reuptake inhibitors, and other medications used for the
24 treatment of serious mental illnesses. The agency shall also
25 limit the amount of a prescribed drug dispensed to no more
26 than a 34-day supply. The agency shall continue to provide
27 unlimited generic drugs, contraceptive drugs and items, and
28 diabetic supplies. Although a drug may be included on the
29 preferred drug formulary, it would not be exempt from the
30 four-brand limit.The agency may authorize exceptions to the
31 brand-name-drug restriction based upon the treatment needs of

1 the patients, only when such exceptions are based on prior
2 consultation provided by the agency or an agency contractor,
3 but the agency must establish procedures to ensure that:

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

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

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

22 2. Reimbursement to pharmacies for Medicaid prescribed
23 drugs shall be set at the average wholesale price less 13.25
24 percent.

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

1 and drug therapies. The agency may contract with a private
2 organization to provide drug-program-management services. The
3 Medicaid drug benefit management program shall include
4 initiatives to manage drug therapies for HIV/AIDS patients,
5 patients using 20 or more unique prescriptions in a 180-day
6 period, and the top 1,000 patients in annual spending.

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

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

28 6. The agency may enter into arrangements that require
29 manufacturers of generic drugs prescribed to Medicaid
30 recipients to provide rebates of at least 15.1 percent of the
31 average manufacturer price for the manufacturer's generic

1 products. These arrangements shall require that if a
2 generic-drug manufacturer pays federal rebates for
3 Medicaid-reimbursed drugs at a level below 15.1 percent, the
4 manufacturer must provide a supplemental rebate to the state
5 in an amount necessary to achieve a 15.1-percent rebate level.
6 ~~If a generic-drug manufacturer raises its price in excess of~~
7 ~~the Consumer Price Index (Urban), the excess amount shall be~~
8 ~~included in the supplemental rebate to the state.~~

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

1 conduct negotiations for supplemental rebates. For the
2 purposes of this section, the term "supplemental rebates" may
3 include, at the agency's discretion, cash rebates and other
4 program benefits that offset a Medicaid expenditure. Such
5 other program benefits may include, but are not limited to,
6 disease management programs, drug product donation programs,
7 drug utilization control programs, prescriber and beneficiary
8 counseling and education, fraud and abuse initiatives, and
9 other services or administrative investments with guaranteed
10 savings to the Medicaid program in the same year the rebate
11 reduction is included in the General Appropriations Act. The
12 agency is authorized to seek any federal waivers to implement
13 this initiative.

14 8. The agency shall establish an advisory committee
15 for the purposes of studying the feasibility of using a
16 restricted drug formulary for nursing home residents and other
17 institutionalized adults. The committee shall be comprised of
18 seven members appointed by the Secretary of Health Care
19 Administration. The committee members shall include two
20 physicians licensed under chapter 458 or chapter 459, Florida
21 Statutes; three pharmacists licensed under chapter 465,
22 Florida Statutes, and appointed from a list of recommendations
23 provided by the Florida Long-Term Care Pharmacy Alliance; and
24 two pharmacists licensed under chapter 465, Florida Statutes.

25 (b) The agency shall implement this subsection to the
26 extent that funds are appropriated to administer the Medicaid
27 prescribed-drug spending-control program. The agency may
28 contract all or any part of this program to private
29 organizations.

30 (c) The agency shall submit a report to the Governor,
31 the President of the Senate, and the Speaker of the House of

1 Representatives by January 15 of each year. The report must
2 include, but need not be limited to, the progress made in
3 implementing Medicaid cost-containment measures and their
4 effect on Medicaid prescribed-drug expenditures.

5 (38) Notwithstanding the provisions of chapter 287,
6 the agency may, at its discretion, renew a contract or
7 contracts for fiscal intermediary services one or more times
8 for such periods as the agency may decide; however, all such
9 renewals may not combine to exceed a total period longer than
10 the term of the original contract.

11 (39) The agency shall provide for the development of a
12 demonstration project by establishment in Miami-Dade County of
13 a long-term-care facility licensed pursuant to chapter 395 to
14 improve access to health care for a predominantly minority,
15 medically underserved, and medically complex population and to
16 evaluate alternatives to nursing-home care and general acute
17 care for such population. Such project is to be located in a
18 health care condominium and colocated with licensed facilities
19 providing a continuum of care. The establishment of this
20 project is not subject to the provisions of s. 408.036 or s.
21 408.039. The agency shall report its findings to the
22 Governor, the President of the Senate, and the Speaker of the
23 House of Representatives by January 1, 2003.

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

26 409.9122 Mandatory Medicaid managed care enrollment;
27 programs and procedures.--

28 (2)

29 (f) When a Medicaid recipient does not choose a
30 managed care plan or MediPass provider, the agency shall
31 assign the Medicaid recipient to a managed care plan or

1 MediPass provider. Medicaid recipients who are subject to
2 mandatory assignment but who fail to make a choice shall be
3 assigned to managed care plans or provider service networks
4 until an equal enrollment of 50 percent in MediPass and
5 provider service networks and 50 percent in managed care plans
6 is achieved. Once equal enrollment is achieved, the
7 assignments shall be divided in order to maintain an equal
8 enrollment in MediPass and managed care plans ~~for the~~
9 ~~1998-1999 fiscal year~~. Thereafter, assignment of Medicaid
10 recipients who fail to make a choice shall be based
11 proportionally on the preferences of recipients who have made
12 a choice in the previous period. Such proportions shall be
13 revised at least quarterly to reflect an update of the
14 preferences of Medicaid recipients. The agency shall also
15 disproportionately assign Medicaid-eligible children in
16 families who are required to but have failed to make a choice
17 of managed-care plan or MediPass for their child and who are
18 to be assigned to the MediPass program to children's networks
19 as described in s. 409.912(3)(g) and where available. The
20 disproportionate assignment of children to children's networks
21 shall be made until the agency has determined that the
22 children's networks have sufficient numbers to be economically
23 operated.When making assignments, the agency shall take into
24 account the following criteria:

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

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

31

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

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

8 (k)1. ~~Notwithstanding the provisions of paragraph (f),~~
9 ~~and for the 2000-2001 fiscal year only,~~When a Medicaid
10 recipient does not choose a managed care plan or MediPass
11 provider, the agency shall assign the Medicaid recipient to a
12 managed care plan, except in those counties in which there are
13 fewer than two managed care plans accepting Medicaid
14 enrollees, in which case assignment shall be to a managed care
15 plan or a MediPass provider. Medicaid recipients in counties
16 with fewer than two managed care plans accepting Medicaid
17 enrollees who are subject to mandatory assignment but who fail
18 to make a choice shall be assigned to managed care plans until
19 an equal enrollment of 50 percent in MediPass and provider
20 service networks and 50 percent in managed care plans is
21 achieved. Once equal enrollment is achieved, the assignments
22 shall be divided in order to maintain an equal enrollment in
23 MediPass and managed care plans. When making assignments, the
24 agency shall take into account the following criteria:

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

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

31

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

5 ~~4.d.~~ The managed care plan's or MediPass primary care
6 providers are geographically accessible to the recipient's
7 residence.

8 ~~5.e.~~ The agency has authority to make mandatory
9 assignments based on quality of service and performance of
10 managed care plans.

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

12 Section 11. Paragraph (a) of subsection (1) and
13 subsection (7) of section 409.915, Florida Statutes, are
14 amended to read:

15 409.915 County contributions to Medicaid.--Although
16 the state is responsible for the full portion of the state
17 share of the matching funds required for the Medicaid program,
18 in order to acquire a certain portion of these funds, the
19 state shall charge the counties for certain items of care and
20 service as provided in this section.

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

23 (a) For both health maintenance members and
24 fee-for-service beneficiaries, payments for inpatient
25 hospitalization in excess of 10 ~~12~~ days, but not in excess of
26 45 days, with the exception of pregnant women and children
27 whose income is in excess of the federal poverty level and who
28 do not participate in the Medicaid medically needy program.

29 (7) Counties are exempt from contributing toward the
30 cost of new exemptions on inpatient ceilings for statutory
31 teaching hospitals, specialty hospitals, and community

1 hospital education program hospitals that came into effect
2 July 1, 2000, and for special Medicaid payments that came into
3 effect on or after July 1, 2000.~~Notwithstanding any provision~~
4 ~~of this section to the contrary, counties are exempt from~~
5 ~~contributing toward the increased cost of hospital inpatient~~
6 ~~services due to the elimination of ceilings on Medicaid~~
7 ~~inpatient reimbursement rates paid to teaching hospitals,~~
8 ~~specialty hospitals, and community health education program~~
9 ~~hospitals and for special Medicaid reimbursements to hospitals~~
10 ~~for which the Legislature has specifically appropriated funds.~~
11 ~~This subsection is repealed on July 1, 2001.~~

12 Section 12. Effective upon this act becoming a law,
13 and notwithstanding sections 409.911, 409.9113, and 409.9117,
14 Florida Statutes, from the funds made available under the
15 Medicare program, the Medicaid program, and the State
16 Children's Health Insurance Program Benefits Improvement and
17 Protection Act of 2000 for the 2001 federal fiscal year,
18 disproportionate share program funds shall be distributed as
19 follows: \$13,937,997 to Jackson Memorial; \$285,298 to Mount
20 Sinai Medical Center; \$313,748 to Orlando Regional Medical
21 Center; \$2,734,019 to Shands - Jacksonville; \$1,060,047 to
22 Shands - University of Florida; \$1,683,415 to Tampa General
23 Hospital; and \$2,231,910 to North Broward Hospital District.
24 Such funds shall be made available in accordance with a budget
25 amendment and the Medicaid plan amendment submitted prior to
26 the close of the 2001 federal fiscal year. This section does
27 not delay implementation of the budget amendment or the
28 Medicaid plan amendment if such is deemed necessary.

29 Section 13. From the funds in Specific Appropriation
30 1002 of the General Appropriations Act for FY 2001-2002,
31

1 \$1,750,000 in non-recurring County Health Department Trust
2 Funds is provided for the following:
3
4 School Health--Hillsborough County \$550,000
5 School Health--Broward County \$500,000
6 School Health--Escambia County \$200,000
7 School Health--Monroe County \$200,000
8 School Health--Dade County \$300,000

9 Section 14. The certificate-of-need workgroup created
10 by section 15 of Chapter 2000-318, Laws of Florida, shall
11 review and make recommendations regarding the appropriateness
12 of current regulations on services provided in ambulatory
13 surgical centers. The recommendations shall be based on
14 consideration of:

15 (1) The consistency of the regulations with federal
16 law and federal reimbursement policies;

17 (2) The effectiveness of the regulations in protecting
18 the public health and safety, promoting the quality of
19 services provided by ambulatory surgical centers, and
20 encouraging the participation of ambulatory surgical centers
21 in the delivery of essential community services; and

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

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

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

28 (c) The availability of essential community services,
29 including trauma, emergency care and specialty, tertiary
30 services; and
31

1 (d) The cost and availability of health care services
2 to all classes of patients, including insured, uninsured,
3 underinsured, and Medicare and Medicaid.

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

6 408.036 Projects subject to review.--

7 (3) EXEMPTIONS.--Upon request, the following projects
8 are subject to exemption from the provisions of subsection
9 (1):

10 (r) For the conversion of hospital-based Medicare and
11 Medicaid certified skilled nursing beds to acute care beds, if
12 the conversion does not involve the construction of new
13 facilities.

14 (s) For fiscal year 2001-2002 only, for transfer by a
15 health care system of existing services and not more than 100
16 licensed and approved beds from a hospital in district 1,
17 subdistrict 1, to another location within the same subdistrict
18 in order to establish a satellite facility that will improve
19 access to outpatient and inpatient care for residents of the
20 district and subdistrict and that will use new medical
21 technologies, including advanced diagnostics, computer
22 assisted imaging, and telemedicine to improve care. This
23 paragraph is repealed on July 1, 2002.

24 Section 16. The Legislature determines and declares
25 that this act fulfills an important state interest.

26 Section 17. It is hereby appropriated for state fiscal
27 year 2001-2002, \$713,493 from the General Revenue Fund and
28 \$924,837 from the Medical Care Trust Fund to increase the
29 pharmaceutical dispensing fee for prescriptions dispensed to
30 nursing home residents and other institutional residents from
31 \$4.23 to \$4.73 per prescription.

1 dollar-for-dollar basis by contributions from the employing
2 institutions, except that this provision shall not apply to
3 state-operated medical and health care facilities, county
4 health departments, federally sponsored community health
5 centers, ~~or~~ teaching hospitals as defined in s. 408.07, family
6 practice teaching hospitals as defined in s. 395.805, or
7 specialty children's hospitals as described in s. 409.9119.
8 If, in any given fiscal quarter, there are insufficient funds
9 in the trust fund to grant all eligible applicants' requests,
10 awards must be based on the following priority by employer:
11 county health departments, federally sponsored community
12 health centers, state-operated medical and health care
13 facilities, teaching hospitals as defined in s. 408.07, family
14 practice teaching hospitals as defined in s. 395.805,
15 specialty children's hospitals as described in s. 409.9119,
16 and other hospitals, birthing centers, or nursing homes where
17 the match is required.

18 Section 20. Paragraph (b) of subsection (4) of section
19 240.4076, Florida Statutes, is amended to read:

20 240.4076 Nursing scholarship program.--

21 (4) Credit for repayment of a scholarship shall be as
22 follows:

23 (b) Eligible health care facilities include
24 state-operated medical or health care facilities, county
25 health departments, federally sponsored community health
26 centers, ~~or~~ teaching hospitals as defined in s. 408.07,
27 nursing homes, family practice teaching hospitals as defined
28 in s. 395.805, or specialty children's hospitals as described
29 in s. 409.9119. The recipient shall be encouraged to complete
30 the service obligation at a single employment site. If
31 continuous employment at the same site is not feasible, the

1 recipient may apply to the department for a transfer to
2 another approved health care facility.

3 Section 21. All the statutory powers, duties, and
4 functions and the records, personnel, property, and unexpended
5 balances of appropriations, allocations, or other funds of the
6 Nursing Student Loan Forgiveness Program are transferred from
7 the Department of Education to the Department of Health by a
8 type two transfer as defined in section 20.06, Florida
9 Statutes.

10 Section 22. Except as otherwise expressly provided in
11 this act, this act shall take effect July 1, 2001.

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